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ABSTRACT

Proceedings of a conference on graduate education in nursing, which sought to provide a forum for discussion of issues and to share the findings and experiences of the graduate demonstration projects undertaken under the aegis of the Southern Regional Education Board's Nursing Curriculum Project, are presented. Contents include: "Purposes of Graduate Education: An Evaluation," Jean A. Kelley; "Overview of Modal Curricular Patterns: Master's Curriculum," LaVerne Gallman; "An Overview of a Doctoral Modal Curricular Pattern," William Field; "Nursing Theory and Practice: A Philosophical Debate," Kathleen Goldblatt; "Essential Content: Nursing Theory and Research," Nita W. Davidson; "Clinical Nurse Specialist in Primary Health Care," Jo M. Jones; "Teaching," Myrtis J. Snowden; "Nursing Practice Administration," Lois C. Halkenes; "Research," Juanita W. Fleming; "Organizations," Ruth C. Seigler; and "Generic Graduate Programs In Nursing," Sylvia E. Hart. Debates on three issues in innovations include: (1) "Satellite Programs and Flexible Scheduling: Can Quality and Integrity Be Maintained?" ("The Case for Outreach Programs," Helen R. Kohler, and "The Case against Outreach Programs," Betty R. Rudnick); (2) "Progression to the Nursing Doctorate: How Can It Best Be Achieved?" ("The Master's Degree as Prerequisite," Elizabeth Lenz and "The Direct Route to the Doctorate," Carolyn Waltz); (3) "Should the Product of Graduate Education Be an Advanced Generalist or a Specialist?" ("The Case for a Comprehensivist," Genevieve Bartol and "The Case for Clinical Specialization," Barbara Brodie). A bibliography and conference program are appended. (SW)

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Graduate Education in Nursing:
Issues and Future Directions

Proceedings of a conference sponsored by the Nursing Curriculum Project
Atlanta, Georgia
December 2-3, 1980

Mary Howard Smith, Editor

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Southern Regional Education Board
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INTRODUCTION

The "Conference on Graduate Education in Nursing: Issues and Future Directions," held in Atlanta on December 2-3, 1980, had the dual purpose of providing a forum for discussion of issues and sharing with the wider regional audience the findings and experiences of the graduate demonstration projects undertaken under the aegis of the Southern Regional Education Board's Nursing Curriculum Project (NCP).*

Graduate education has been a primary concern of the NCP throughout the nine years of its work. In the first phase of the NCP, one recommendation of the seminar charged with proposing a congruent system of nursing education stressed the importance of strengthening the graduate sector. When, after the initial phase of the NCP, the Kellogg Foundation made funds available to demonstrate the several recommendations, two projects in graduate education were among the first demonstrations to be approved — one at the University of Alabama-Birmingham and the other at the University of Tennessee-Knoxville.

These demonstration projects furnished the impetus for the Conference on Graduate Education in Nursing. The Conference as a whole was enthusiastically received and participated in by some 70 graduate nursing faculty members, who came from all 14 Southern states plus Ohio and Pennsylvania. So many requests were received for the various papers that the NCP staff has collected them *ex post facto* and they are presented herewith. The papers by Kathleen Goldblatt, Nita Davidson, and Sylvia Hart reflect the concerns and conclusions of the graduate demonstration projects.

Patricia T. Haase, Director
Mary Howard Smith, Conference Coordinator
Nursing Curriculum Project

*Funded by the W. K. Kellogg Foundation of Battle Creek, Michigan, 1972-76 and 1977-81.

DIRECTORY OF SPEAKERS

GENEVIEVE BARTOL, Associate Professor of Nursing, Duke University, Durham, North Carolina

BARBARA BRODIE, Professor of Nursing, University of Virginia, Charlottesville

NITA W. DAVIDSON, Professor of Nursing, University of Alabama in Birmingham

WILLIAM FIELD, Assistant Dean for Graduate Program, University of Texas at Austin

JUANITA W. FLEMING, Professor of Nursing and Assistant Dean for Graduate Education, University of Kentucky, Lexington

LAVERNE GALLMAN, Associate Professor of Nursing, University of Texas at Austin

KATHLEEN GOLDBLATT, Professor of Nursing, University of Alabama in Birmingham

SYLVIA E. HART, Dean, College of Nursing, University of Tennessee, Knoxville

VIRGINIA JARRATT, Dean, College of Nursing, University of Arkansas for Medical Sciences, Little Rock

LORITA D. JENAB, Dean, School of Nursing, West Virginia University, Morgantown

JO M. JONES, Assistant Professor of Community Health Nursing, Emory University, Atlanta

JEAN A. KELLEY, Assistant Dean, Graduate Programs, School of Nursing, University of Alabama in Birmingham

HELEN R. KOHLER, Associate Professor of Nursing and Director, Outreach Nursing Programs, University of Maryland, Baltimore

ELIZABETH R. LENZ, Director, Doctoral Program, School of Nursing, University of Maryland, Baltimore

LOIS C. MALKEMES, Patient Care Administrator, University Hospital, University of Arkansas for Medical Sciences, Little Rock

BETTY R. RUDNICK, Professor of Nursing, Texas Woman's University, Denton

RUTH Q. SEIGLER, Executive Director, South Carolina State Board of Nursing, Columbia

MYRTIS J. SNOWDEN, Director of Graduate Education, School of Nursing, Louisiana State University Medical Center, New Orleans

CAROLYN WALTZ, Professor of Nursing, University of Maryland, Baltimore

PURPOSES OF GRADUATE EDUCATION: AN EVALUATION

Jean A. Kelley

Challenge to Graduate Programs in Nursing

Graduate education in nursing is a special blend of the purposes and values held by graduate education in general mixed with those held by professional education. Using this distinct combination of educational approaches, graduate education in nursing for the Southern region was conscientiously conceived during the 1950s when the original six master's programs were established. It experienced acceleration to an adolescent state, with the typical teenage identity crisis during the 1960s, and entered young adulthood with enthusiasm and productivity during the 1970s with growth to 41 master's and 4 doctoral programs. As graduate professional education in nursing in the South begins this decade of its middle age, an accounting of its past and present purposes is essential to determining what needs to be retained or reinstated. Moreover, a sensitive examination of issues in graduate education is basic to seeking direction for its next inevitable stage of life known as "middlescence," which is due to arrive around the turn of the century. An evaluation of the purposes of graduate education at this time of life may help nurse faculty in the region recognize the need for flexibility and for varying directions in graduate programs in nursing, so that the learning needs of students pursuing different career goals and the health care needs of society are met.

Essentially, pluralism, flexibility, and diversity in graduate education in nursing are the foundation for reforming, restoring, and moving higher education forward into the 21st century (American Nurses' Association, 1978). As the teacher of clinicians, educators, researchers, administrators, and consultants, graduate education in nursing is in a powerful position to sway the nursing world. It is in an enviable position to influence the setting of nursing priorities and to offer assistance with nursing care delivery problems. However, graduate professional education in nursing cannot be an effective model and resource for fulfilling the primary purpose of nursing education — that of producing competent leaders who will influence the health-illness state of human beings — until it performs a thorough self-assessment and takes corrective action.

A call for revision of graduate professional education to cope with long existent and emerging problems was made during the last decade by Ann Heiss in a major study of graduate schools and by Mayhew and Ford in a study of professional education (Heiss, 1970; Mayhew and Ford, 1974). However, little change has occurred in graduate education since it was imported in the 19th century from Europe, based on the German model which emphasized specialization and research and the English ideal of concern for the liberal arts. Nevitt Sanford (1976), in revisiting the values held by graduate faculty during the mid 1930s, noted that faculty of that era:

1. Treasured a diversity of ideas in which faculty and students learned how to differ by taking, defending, and expressing their own views on issues.
2. Demonstrated general concern for students both during graduate study and after graduation. Students were seen as the center of graduate education. Each student was viewed as a promising scholar who was to be nurtured, challenged, and developed.
3. Expected students to work the 80 hours per work week of their professors in a collegial relationship and not to question but to trust the academic requirements while passionately pursuing knowledge.
4. Treated each other and students on a formal, last-name basis.

Graduate education today has changed, but only in relation to "the purposes for which the structure is used and the spirit with which it is managed" (Sanford, 1976). In particular: (1) the motives of faculty and students are more toward preparation for a professional role; (2) the climate is one of competitiveness and decreased tolerance for diversity of ideas; there is more like-mindedness, which is a characteristic that accompanies specialization; and (3) the faculty-student relationships are less collegial; students are viewed as a resource to be used while faculty are seen as gatekeepers to a professional career. Sanford pleaded for reinstatement of several old values of graduate education:

1. *Intellectual passion*, or problem-oriented inquiry which uses knowledge of various disciplines to fit things together, versus *intellectual analysis*, or taking problems apart to the smallest micrometer without any synthesis and application.
2. *Tolerance* for a hotbed of deviant ideas in research and clinical work versus *like-mindedness*.
3. Humanistic *concern for students* by faculty who role-model the behaviors expected in the students.

The future of graduate professional education in nursing is dependent upon the present. In planning for the future several questions must be raised and

answered today in order to reform, restore, and refine the purposes of graduate professional education in nursing:

What is graduate education?
What is professional education?
What is nursing?
What is graduate education in nursing?
What is the state of graduate education in nursing?

Nature of Graduate Education

What is the nature of graduate education in general in a time of changing health care needs? What is the value of graduate education to the individual student and to society? A review of the past reveals that several different purposes exist. The classical purposes are to: (1) transmit knowledge through *teaching;* (2) extend knowledge through *research*; and (3) provide *services* to society through consultation and practice. Thus teaching, research, and services are the three traditional purposes. However, graduate faculty may not accept all three purposes or may place different weights on each purpose.

A specific graduate program may hold a number of different ideas as to its *purpose.* One traditional purpose is the dissemination of the ideals of its civilization, or focusing on preserving *society.* However, conflict may arise with this purpose between faculty who believe they should teach from a culture-free goal perspective and those who teach from an established value and tradition system. If the purpose of graduate education is to develop societal awareness in students, then the graduate program of studies should reflect this concern for society and equip the learner with problem-solving tools and social change techniques. *Another traditional purpose* is to develop the good and worthy human being, or focusing on the concept of intellectual *"man."* If this is the primary purpose of graduate education, then the graduate program of studies should lead the student to individual and maximum development, with the outcome being an enlightened person with a broader perspective on life. Still *another purpose* of graduate education is the rational pursuit and extension of the boundaries of *knowledge.* If this is the major purpose, then the graduate program of studies should reflect efforts to educate scholars for a lifetime of research and inquiry into phenomena. Next there is the purpose of *accruing and applying knowledge* while giving service to society or focusing on the *application of knowledge.* If this is the primary purpose of graduate education, then the program should reflect concern for preparing professionals who continue to learn during a lifetime of inquiry into practice or teaching others. How each of these purposes (society, man, knowledge, applied knowledge) are viewed and prioritized by faculty will influence the nature of graduate education in that institution. For example, faculty who believe in and prioritize the last purpose (application of knowledge) will view themselves more as a center for learning than as a center of teaching in which students and faculty engage as colleagues in passionate inquiry into a diversity of ideas and research for the eventual improvement of practice in that field.

Generally it is agreed that graduate education is preparation beyond the baccalaureate level that involves *specialization* in a designated field, *mastery* of a common core of knowledge, *independent study* aimed at broadening one's perspective in the field of specialization, a *research orientation* designed to foster inquiry into phenomena in the field, and a *critical understanding of issues* relevant to the specialty. Graduate education carries with it an obligation for students to question the models offered to them by faculty, professionals, technicians, and employers. In the words of Ann Heiss, graduate education is ". . . a generative and regenerative process; continued renewal and evaluation of the ends and means of the process need to be practiced by both the designers and by its consumers" (Heiss, 1970, p. 103).

However, conflict prevails in relation to the *overall concept* of the nature of graduate education. Conflict exists over whether graduate education should be preparation for a professional career or an academic life. More specifically, conflict exists over whether graduate education should prepare students to function as a teacher, researcher, or practitioner. Conflict exists over whether the learner should be an independent or faculty-dependent seeker of knowledge. Conflict exists over the educational outcome; that is, should the outcome be individual development of the learner, societal development of the learner, a foundation for continuous development in the learner, or a combination of all three?

In an effort to resolve the conflict over the nature of graduate education, the Council of Graduate Schools in the United States and the Association of Graduate Schools in 1966 defined education at the master's level as post-baccalaureate study in a specialized field, one to two years in length, characterized by a coherent pattern of courses, a comprehensive examination, a research orientation, and some type of teaching experience. Doctoral education was viewed as post-master's study leading to creative scholarship and research as well as possible preparation for practice. More recent statements by the two organizations stressed that graduate education is preparation for active scholarship and research leading to a lifetime of intellectual inquiry (Association of Graduate Schools, 1979).

Nature of Professional Education

Professional education, on the other hand, conforms to recognized characteristics that give direction

to the curriculum and give rise to issues and problems. Professional education is based on a distinct ideology. First there is an acknowledged *fund of information or knowledge* — the specific facts, basic ideas, concepts, and thought systems — that makes it recognizable as a learned discipline. That knowledge is drawn from the humanistic arts as well as the behavioral and biophysical sciences. Professional education integrates varying scientific perspectives and arts into its practices. Next, there is a *method of inquiry* that is used in practice, that is, the "nursing process." The techniques of practice are more than technical skills. These techniques are standardized competencies expected both by the professional school as the essential skills to be mastered and also by the public that grants authority, trust, and autonomy to the profession. Professional education sets forth the theory of practice — the concepts with which a professional practices and the ways professional activities will lead to a better world. Professional education is concerned with teaching the arts and techniques that make up a professional's skills. Another essential characteristic of professional education is that it transmits an ethic or set of principles that are binding on practitioners. This code directs an individual professional to serve society in certain ways and is a means of protecting the public from incompetent practitioners. Furthermore, professional education assumes there is an *institutional setting* within which professional activities are performed. Therefore, professional education is concerned with assisting the novice to learn the established ideology, or theory of practice, in a specific discipline (Mayhew and Ford, 1974, pp. 1-3).

The main purposes of professional education, according to Mayhew and Ford, are to: (1) attract a sufficient number of students to insure an adequate supply or *quantity of practitioners*, and (2) graduate competent professional practitioners, or provide for *quality in practitioners*. In regard to the first purpose, professional schools have a monopoly on the recruitment and with it an obligation to collaborate with the profession to insure entry of sufficient numbers of qualified students, otherwise shortages and inadequate services to society may result. In regard to the second purpose, professional education should be aimed at communicating the professional ideology — its knowledge, method of inquiry, code, and commitment to serve and improve society — through preparing the most competent practitioners (Mayhew and Ford, 1974).

There is no generally accepted, common curriculum model for professional education except for that used in medical education. Instead there is a diversity of models available to accommodate different missions of the various professions. Three basic models proposed by Mayhew and Ford are:

1. *Academic Professional Model*, which includes undergraduate and graduate education, professional sciences and application, and support work drawn from the arts and sciences;
2. *Balanced Model*, which includes a common baccalaureate base followed by specialization at the graduate level that does not require more than one quarter of the curriculum, with the remainder reserved for general culture, context, and related coursework;
3. *Assembly Model*, based on gathering groups of principles that are used for organizing content designed to prepare a competent practitioner (Mayhew and Ford, 1974).

Nature of Nursing

Nursing is a practice-oriented health field. It is a humanistic science that is concerned with the delivery of services to persons in need of health-illness care. It involves assisting people to achieve a state of self-care or to accept a state of coping with health problems. It contributes to a health continuum which ranges from health maintenance and recovery at one end to acceptance of death at the other end. It is an art with a scientific basis that is delivered through a dynamic, interpersonal process. It is learned through a long arduous educational process which allows time for students to master its ideology — its theory of practice, its knowledge base, its practice techniques and ethics. Nursing applies its knowledge to humans in need of health care in a wide variety of different settings rather than in a few circumscribed institutional settings. Therefore, the complexity and range of techniques required to be an effective, competent nurse necessitate graduate programs that are planned, taught, and evaluated by professional, competent nurse faculty with expertise in the *science of nursing*.

Nature of Graduate Education in Nursing

Nursing began as a practice-oriented health field. At the graduate level it wandered off into being concerned with preparation for functional roles, in particular the preparation of educational administrators, teachers, and researchers, or the transmitters and generators of knowledge. During the last decade it showed evidence of returning to its original orientation, but in an improved form, by stressing the preparation of clinicians or validators of knowledge in practice.

In the mid 1960s both the National League for Nursing (NLN) and American Nurses' Association (ANA) set forth statements on graduate education in nursing. In a 1967 newsletter, the NLN indicated the *purpose of graduate education in nursing* was to prepare nursing leaders through professional career

development. The end-product of a graduate curriculum in nursing should be a self-directed practitioner who is an effective leader and productive contributor to the profession. Two years later, in 1969, the ANA published its first position paper on graduate education, which called for the preparation of nurse clinicians capable of improving nursing care through the advancement of both nursing theory and practice (Commission on Nursing Education, 1969). Both organizations pleaded for graduate professional education which would transmit the essential advanced knowledge and techniques of nursing, develop within the learner a style of thinking or method of inquiry, and assist each student with the creation of a framework within which to practice. Both statements were geared to giving direction to graduate education at the master's level, not the doctoral level. Consequently, graduate education in nursing during the 1960s and 1970s focused more on the purposes of master's education. Traditionally it was based upon the baccalaureate generalist base in nursing, provided a coherent pattern of courses and content in a specialty field, and provided opportunities for role development as a teacher, administrator, or clinician.

More recent statements by the NLN and ANA indicate a concern for graduate professional education at both the master's and doctoral levels. In 1978, the NLN proposed that graduate education in nursing at the master's level should provide for the:

1. acquisition of knowledge from the sciences and humanities to support nursing practice and role development;
2. expansion of knowledge for the advancement of nursing practice;
3. development of expertise in a specialty area of nursing (National League for Nursing, 1978).

Its November 1980 statement on doctoral education stipulated that the *purpose of graduate education* at this level is the ". . . development, expansion and application of knowledge" in a discipline that ". . . encompasses scholarship and practice" (National League for Nursing, 1980). Diverse educational models for doctoral education in nursing were proposed as the best means for generating and validating nursing knowledge. Meanwhile, the ANA in 1978 published a second position paper on graduate education in nursing which addressed master's, doctoral, and nontraditional approaches for graduate education (Commission on Nursing Education, 1978). This comprehensive statement urges the preparation of ". . . highly competent individuals who can function in diverse roles, such as clinical nurse generalist, clinical nurse specialist, researcher, theoretician, teacher, administrator, consultant, public policymaker, systems manager, and colleague on multidisciplinary teams" (Commission on Nursing Education, 1978, p. 1). Graduate education at the master's level was viewed as having: (1) advanced clinical content for competence as a generalist or specialist; (2) clinical nursing theory and research; and (3) preparation for a role in administration, teaching, or consultation. Preparation of nurses at the master's level was seen as the first phase of the path toward doctoral education which will soon be the expectation for all nurse faculty. Doctoral programs in nursing were perceived as directed toward: (1) theory development and testing; (2) creation of more sophisticated research designs for studying nursing and health problems; and (3) expansion and application of knowledge relevant to the care of persons experiencing health-illness.

In keeping with the ANA's belief about the need for diversity, pluralism, and flexibility in graduate education, nontraditional approaches were encouraged. For example, the position paper suggested interinstitutional graduate exchange programs, consortiums, outreach programs, and generic master's or doctoral programs in which students with baccalaureate degrees in a field other than nursing are enrolled in a graduate program in nursing and awarded the first professional degree in nursing. Nurse educators were challenged through the second position paper to give thought to the nature and character of graduate education at the end of this century and to reform graduate education in a way that nursing might have a positive impact on the health care system in the U.S. and other countries. In particular nurse faculty were asked to consider the future roles to be played and curriculums to be designed for entry into the 21st century. More specifically nurse educators were encouraged to consider interdisciplinary health education at the graduate level as the way of the future if the multitudinous health care needs of society are to be met.

State of Graduate Education in Nursing

Given that nursing is a form of professional education, what is its state at the graduate level?

Master's

Historically, graduate education in nursing was restricted to the master's level. During the 1950s and 1960s it focused on functional preparation. In particular it focused on the preparation of teachers. Even in programs that indicated nursing was the major focus of the program, teacher education was the real purpose. Four classical courses were considered as essential content: philosophy of education, curriculum development, teaching strategies, and tests and measurements. This knowledge constituted the core for the *science of teaching*. However, application of the science of teaching to the practice of nursing was often lacking. Maxwell (1968) noted during this era that both educational administrators and

students complained that nurse faculty prepared in this manner lacked competency in teaching nursing theory and practice. Subsequently the 1960s position papers from the NLN and ANA called for graduate education in nursing to adopt as its purpose the preparation of competent, self-directed practitioner-leaders. Consequently many master's programs were revised with advanced nursing content in a specialty as the major focus and preparation for a functional role relegated as a minor, or ignored. Grossman suggested in 1972 that advanced nursing competence could be achieved in a master's curriculum one year in length, but that preparation for a functional role in teaching should be the focus of a second year of study or be provided through post-master's or doctoral study (Grossman, 1972, p. 467). McLane's (1978) recent research on "Core Competencies of Master's Prepared Nurses" revealed a need for graduate curriculums to have as their purpose the preparation of nurses for dual roles, as opposed to preparation first as a clinician followed by socialization into a teacher or other role. She recommended dual role socialization as a goal of graduate education in nursing at both the master's and doctoral levels.

Meanwhile, the ANA's second position paper on graduate education called for pluralism, diversity, and flexibility. Graduate programs in the South responded to this challenge by the initiation of several quality-controlled outreach master's degree models, the implementation of at least one generic master's program in nursing, and the introduction of interdisciplinary health education models, especially in the area of nursing service administration. Few consortium arrangements or interinstitutional exchange programs have been considered. Perhaps the greatest awakening in master's education during the 1970s was the sudden recognition and respect accorded role preparation. For more than a decade, functional role preparation was taboo. The critical need for well-prepared nursing service administrators and nurse faculty competent both in practice (science of nursing) and teaching (science of teaching) has caused a reinstatement of legitimacy to functional role development. What remains to be seen is if graduate faculty will allow for flexibility and diversity in master's curriculums to permit new and emerging roles to evolve, for example, health marketing, health resources manager. What remains to be seen is if graduate faculty will keep an open mind and tolerant attitude as the generic master's and generic doctorate are being tested as a primary purpose of graduate education in the future. Master's programs in nursing need to avoid getting locked into ultra-traditional curriculums which provide only for advanced nursing, research, and elective components, and restrict opportunities for functional role development.

Post-Master's

One relatively untapped area of graduate education that nursing has overlooked is the post-master's. Today nursing is faced with a knowledge explosion, a rapid expansion of innovative educational and health care programs, and a demand by society for quality nursing services. There is just so much that can be learned in a one- or two-year master's program. There are additional knowledges and techniques that could be acquired through post-master's study. In the field of education, the 30-hour post-master's certificate or educational specialist degree is meeting a special need of the profession and society. Some graduate programs in nursing are moving in this direction with well-established post-master's study in nursing service administration, oncology nursing, and nurse teacher education. Interdisciplinary education and interinstitutional cooperation are characteristic of most post-master's efforts. The extent to which post-master's certification and a degree designation become a reality in this decade rests with us, the graduate faculty who are willing to pioneer with this purpose of graduate education. The Southern region could take the leadership in implementing the post-master's movement in the U.S.

Doctoral Study

> Doctoral study in nursing has evolved with the development of the discipline. Nursing began as a practice-oriented discipline consisting of technically trained apprentices. It slowly eased into academia and professional education by the inclusion in its educational programs of both the theory and practice of nursing, relevant knowledges from the arts and sciences which fostered professional decision making, research on practice, and leadership in solving health care problems. It . . . acquired differentiation according to levels of preparation with the BSN being viewed as the generalist, the MSN as the specialist or advanced generalist, and the doctorate as the nurse scholar-researcher-clinician who may or may not be prepared also for a functional role as an educator, administrator, consultant, or statesperson (Kelley, 1978, p. 12).

Historically, doctoral study for nurses has been available through a variety of sources. First, there is the choice of doctoral study in another discipline. When this choice is exercised, nurses frequently spend much time making up deficiencies and may be socialized into the role of that discipline while being desocialized from nursing. This study may lead to any one of several typical degrees, for example, the Ed.D. or Ph.D. Since 1927, when the first doctoral

degree was awarded to a nurse, this has been the program of choice selected by a majority of nurses. In particular the doctorate in education was chosen to prepare nurses for a role as an educator or educational administrator. During the decade of the 1960s another choice became available, the nurse scientist approach. In this type of doctoral program, nurses studied a related behavioral or biophysical science and acquired its method of thinking and techniques of research, while the study and application of that science to nursing were expected but often overlooked as a minor focus. This type of doctoral study led to the Ph.D. in the science studied and was designed to prepare a cadre of researchers to study nursing phenomena. Its cost and lack of impact led to its lingering death. During the late 1960s nursing leaders recognized the need for a new type of doctoral program: a *doctoral program in nursing*, which permitted nurses to stay in the primary discipline of nursing while generating and validating knowledge about human beings experiencing health-illness. Therefore, in recent times, there has been made available the choice of an *academic or research-oriented doctorate in nursing*, which provides for discovery of new knowledge that may or may not have practical application. It is concerned with *describing, explaining,* and *predicting phenomena* and leads to the Ph.D. degree. Another principal choice is that of the *professional or practice-oriented doctorate in nursing*. It comes in two varieties. The first variety of doctorate is the model found in law or medicine. It is based on baccalaureate study in any field, plus at least three years of professional education, and leads to the first professional degree in that discipline, for example, Doctor of Jurisprudence, Doctor of Medicine, or the new Doctor of Nursing by Case Western Reserve. This type is known as the first professional degree or the generic doctorate. The second variety is more common in nursing. It builds upon the first and second professional degrees in nursing at the baccalaureate and master's levels and is based upon the belief that substantive content in nursing exists and can be extended at the doctoral level (Cleland, 1975). It is concerned not only with *describing, explaining,* and *predicting phenomena* in nursing but also with *prescribing* scientifically based practices. It leads to the D.S.N. or D.N.S. degree.

Even with the availability of only two major types of doctoral programs in nursing there is much diversity. The focus or purpose may be on clinical competence, theory development and research, preparation for a functional role, or any combination of these. The degree awarded may be the Ed.D., Ph.D., D.N.S., D.N.Sc., D.S.N., or D.N. Basically the purposes of these principal types of doctoral programs may be differentiated as follows:

1. *Research-Oriented, Academic Degree* has as its purpose to train students for scholarly or research activities. It is directed toward acquisition or generation of new knowledge. It requires at least three years of full-time post-baccalaureate study in the subject matter, methods in the field of study are mastered, and the capacity for systematic, original research must be demonstrated. It leads to the Ph.D. degree or, in one instance, the Ed.D.
2. *Practice-Oriented, Professional Degree* has as its purpose the training of students for professional practice. It is directed toward transmission and application of existing knowledge or the validation of knowledge. Its length is similar to the research degree; it is concerned with acquiring a command of existing knowledge with a broader emphasis and practical application. It involves a critical appraisal of new and varied research findings and requires a successful demonstration of application of current knowledge in the field to the solution of meaningful problems in the practice of the profession. It leads to a degree that is more descriptive of the field of study, for example, the D.S.N.

Today there are 22 viable doctoral programs in nursing listed with the NLN, of which 15 lead to the academic or research-oriented degree while only seven lead to the professional, practice-oriented degree. Regional distribution of doctoral programs shows that:

- 7 programs are located in the East, 4 are research and 3, practice degrees;
- 6 programs are located in the Midwest, 4 are research and 2, practice degrees;
- 5 programs are located in the West, 4 are research and 1, a practice degree;
- 4 programs are located in the South, 3 are research and 1, a practice degree.

However, approximately 30 or more doctoral programs in nursing are in the planning stage.

With less than 3,000 out of 1½ million nurses prepared at the doctoral level and a high demand for such programs, graduate faculty will need to make a more rigid differentiation between the two major types of doctoral programs in relation to philosophy, content, and outcome, as well as to assess critically their faculty strengths and other resources, before venturing to develop one type or the other. One practical framework to use in making a sound judgment between doctoral programs in nursing is one that involves comparing the *knowledge emphasis*, the *major focus*, the *nature of the preparation*, and the *program outcome* (MacPhail, 1978, p. 6):

1. *Knowledge*

   While the Ph.D. program is concerned with extending and generating knowledge in general,

the D.S.N. program is concerned with expanding and generating knowledge applicable to improving nursing practice.

2. *Focus*

   While Ph.D. programs emphasize intellectual inquiry for a lifetime of learning, the D.S.N. program emphasizes a lifetime of inquiry into nursing practice for the improvement of health care delivery.

3. *Preparation for Practice*

   While the nature of preparation in the Ph.D. program is the development of research methods and techniques for the advancement of the discipline, the D.S.N. program is concerned with the development of nurse scientist methods and skills for application to the advancement of nursing practice.

4. *Outcome*

   While the Ph.D. program outcome is a nurse researcher, the D.S.N. program outcome is the nurse-clinician-researcher or the newer model: nurse scientist.

The generic doctorate (D.S., or the first professional degree, currently awarded by Case Western Reserve) may be examined with this same framework:

1. *Knowledge*

   Is concerned with interpreting or reinterpreting existing knowledge, not with generating or validating knowledge.

2. *Focus*

   Is concerned with inquiry into general nursing practices, not with specialty practice.

3. *Preparation for Practice*

   Is concerned with preparation as a generalist, a nurse with a broader decision-making base who is eligible to take the State Board Test Pool Examinations for licensure as registered nurse.

4. *Outcome*

   Produces a nurse with skills of inquiry and practice for basic clinical nursing in primary, acute, and long-term care settings.

Nursing at the doctoral level has proceeded at a pluralistic and logical pace, first by preparing nurses as educators and educational administrators through doctoral programs outside of nursing, second by preparing nurses as researchers through study in related behavioral and biophysical sciences, and more recently, by preparing nurses in the discipline of nursing as researchers or nurse-clinician-researchers. Nursing has developed a diversity of educational models at the doctoral level. Graduates of all types of doctoral programs are essential to breaking the health frontiers with new knowledge and for validating knowledge and techniques for the improvement of practice. Since the 1960s the enrollment of nurses in doctoral programs in nursing has surpassed the enrollment of nurses in doctoral programs outside of nursing. However, a majority of the doctoral programs in nursing are of the academic or research type, not the professional, practice-oriented type. Nurses should question the purpose of doctoral education in nursing. Nurses should question what society needs most from the discipline — more and better researchers or more and better nurse-clinician-researchers.

Post-Doctoral Study in Nursing

Another form of graduate education that has been neglected by nursing is post-doctoral study. With a majority of nurses prepared at the doctoral level in fields other than nursing, post-doctoral study in nursing should be, but rarely is, available. The few post-doctoral fellowships awarded to nurses tend to be designated for research in a related behavioral or biophysical field, for example, physiology. Yet nursing as a humanistic health science has experienced a knowledge development and explosion, has developed research sophistication, and has a need to verify its body of knowledge and techniques of practice. Post-doctoral study in nursing could assist nurses already prepared at the doctoral level within and without nursing to refine nursing's terminology into a precise language of concepts, models, frameworks, and theories as well as to identify, classify, and evaluate its knowledge for use as systematic guides in nursing practice. The purpose of post-doctoral study in nursing should be the further development, expansion, and application of nursing knowledge.

Future Direction of Graduate Education in Nursing

According to Ann Heiss, faculty who plan graduate programs are afflicted with retrogressive vision and inertia toward educational change and reform (Heiss, 1970). The problems with graduate education are the same today as in years past; they have changed only in intensity and size. To face the future effectively, graduate faculty will need to be foresighted and reconcile the divergent goals of individual students with the goals of professional graduate education and the health care needs of society. Graduate programs will need to focus on facilitating learning more than on teaching. Students will need to be liberated from preoccupation with grades and examinations. This learning should be humanistic and collegial rather than dehumanistic and competitive. This [learning] should be reinstated as the primary purpose of graduate education (Heiss, 1970). More diversified methods of learning and alternatives for scheduling time to learn will become

common in an electronic age. With interdisciplinary knowledge, faculty and students should have increased access to relevant information from a variety of fields. Graduate education should become individualized, with increased involvement of graduate students in its design. Better articulation with undergraduate education will become a reality, especially in relation to research and nursing content. A sufficient number of competent nurse-clinician-teachers and talented students as well as adequate financial support will become characteristic of graduate education in nursing (Heiss, 1970). Innovative approaches, such as extra-organizational schools, institutes, and centers for cooperative curriculum offerings or facilities, may result in joint degrees or sharing scarce resources.

The purposes of graduate education will need to be monitored for change. Historically, graduate education has had five major purposes:

1. To produce learned persons during a cult of specialization and professionalization.
2. To prepare teachers.
3. To prepare researchers and scholars.
4. To prepare practitioners.
5. To serve a custodial function or as a substitute for work (Mayhew and Ford, 1974).

To move forward into the 21st century nurses must face the issues of:

Blending the established sciences and arts with nursing science;

Achieving a balance in curriculums between the theory and the techniques of practice;

Reconciling emphasis on role development;

Living with both specialization and advanced generalization;

Restructuring the research orientation.

My forecast for the future of graduate education in nursing, based on the Beaufort Scale which depicts the force of wind, is as follows:

> Graduate education at the *master's level* will be stirred by a moderate breeze which raises dust and loose paper and moves small tree branches. Reform of master's education could reduce this force to a calmer breeze; lack of reform may lead to a hurricane. It is time to give this neglected middle child some attention.
>
> Graduate education at the *doctoral level* is in a fresh, strong gale which breaks twigs off some trees, uproots other trees, and causes some structural damage. Progress will not be impeded; widespread damage and devastation will not occur, provided nurse faculty are guided by established standards for doctoral study specified by the ANA, NLN, Association of Graduate Schools, and the Council of Graduate Schools.
>
> Graduate education at the *post-master's* and *post-doctoral levels* is in for a light breeze in which wind is felt on the face and leaves are rustled and a few wind vanes are moved.

My weather prediction is that with your input during this conference, graduate education in nursing will survive this variable wind storm and come out more individualized, more humanized, more collegial, more interdisciplinary, more flexible, more broadening, more diverse, and more relevant.

OVERVIEW OF MODAL CURRICULAR PATTERNS: MASTER'S CURRICULUM

LaVerne Gallman

One of my colleagues emphasizes the importance of definitions to clarify the focus of a discussion and to provide guidelines; therefore, even though all of us here have knowledge about the meaning of "Modal Curricular Patterns," the following dictionary definitions are shared with you:

> *Modal* (adjective): Pertaining to form without reference to substance; Most frequent; Typical.
>
> *Mode* (noun): Prevailing or current style, or fashion.

I suggest that the "typical" (modal) master's program in nursing provides the opportunity for students to acquire advanced knowledge from the biological and social sciences, to develop competency in selected specialized clinical and functional areas, to test theories in nursing practice, to plan and implement research problems, to evaluate research in nursing, to initiate leadership actions for the purpose of influencing positive change in the health care delivery system, to engage in collaborative relationships with others to improve health care, and to provide a foundation for doctoral study. You, no doubt, recognized that the "typicalness" is influenced by the statement, adopted by the Council of Baccalaureate and Higher Degree Programs, concerning the characteristics of graduate education in nursing leading to the master's degree. So my responsibility is to provide an overview of a "typical" curricular pattern which reflects the above-mentioned opportunities for master's level students.

In order to do these things we must have students who are capable of being successful; therefore, every master's program has admission requirements. The requirements may vary but the usual list includes a minimum grade point average, minimum score on the Graduate Record Examination (GRE) or Miller Analogies Test, graduation from a baccalaureate program accredited by the National League for Nursing, current licensure as a registered professional nurse, and three letters of reference. The graduate program of the School of Nursing at the University of Texas at Austin (UT-Austin) is an integral part of the Graduate School and admission requirements of the Graduate School also must be met.

The students have individual goals which are influenced by many factors, but there is a framework within which they work toward the goals. The time framework is 36 semester hours, and students individualize their programs through deciding their course loads each semester. Approximately 50 percent of the master's students in nursing at the University of Texas at Austin are part-time students.

Philosophically the faculty believe that "education in nursing prepares for a tripartite role of practice, function, and research, with emphasis changing progressively through the sequence of baccalaureate, master's and doctoral programs."

Further, the faculty of this modal program (UT-Austin) believe that:

> The master's program, organized on concepts basic to nursing, offers students the opportunity to practice in selected learning experiences which afford familiarity with the clinical and role skills necessary to design, initiate, and execute high-level performance in collaborative roles with colleagues in nursing and other disciplines.
>
> . . . The study of philosophies, theories, and research in nursing and related fields aids master's students in synthesizing a conceptual framework.

The objectives for the master's program reflect a focus on competence in a selected clinical area, role development in a functional area, testing theories in relation to nursing knowledge and practice, critical analysis of research with relevance for nursing leadership actions, and research problems.

Objectives of the Master's Program

The graduate of the master's program facilitates the adaptation of the client's system by:

1. performing with expert competency in a specialized clinical area relative to meeting the adaptation needs of patients/clients;
2. effectively performing the responsibilities of the complex functional roles of teacher or administrator within educational or health care delivery systems;
3. testing theories in relation to their contributions to nursing knowledge and practice;
4. critically analyzing and selectively utilizing research that has relevance for the improvement of nursing practice;
5. proposing courses of action relative to social,

legal, economic, and political issues that impact on nursing and health care;

6. initiating innovative leadership actions that influence positive change in the health care delivery system;
7. designing professional models and research problems that serve to improve the quality of health care.

As with other modal curricular patterns, there is a conceptual framework. The UT-Austin faculty selected an adaptation model (Roy's) to develop the curricula. This model is used to depict major concepts and theoretical formulations. The Chater model depicts the relationship among three components in the curriculum: student, subject (knowledge), and setting (resources).

What curriculum pattern has evolved from the philosophical beliefs, objectives, and conceptual framework?

First, there are required (core) courses which all students must take:

Theoretical Foundations of Nursing Process
Professional Nursing: Influences and Issues
Fundamentals of Research

Students elect a clinical or functional major. There are 12 semester hours included. The choice of clinical majors includes psychiatric/mental health nursing, medical-surgical nursing, and maternal/parent-child nursing. The functional areas are nursing service administration and teaching.

Within each of the clinical majors there is some flexibility in choice of courses. There are two required courses and two others selected by the student. For example, students who are majoring in maternal/parent-child nursing (MPCH) now have three tracks from which to elect a focus: Maternal Child Nursing Faculty Focus, High Risk Perinatal, or Family Health Consultant (see figure 1). The three approaches to a major in MPCH were approved this fall. The plan evolved from faculty commitment to (1) seek ways of meeting individual needs and interests of the students, and (2) be aware of the changes occurring in the health care delivery system in relation to preparing people to assume roles in a complex system.

Note (in figure 1) that in all three tracks, there are two required courses: Overview of Maternal/Parent-Child Health and Conceptual Basis of MPCH. Faculty believe that the content in these two courses is essential in all of the tracks.

Students majoring in psychiatric/mental health nursing have two required courses: Psychotherapeutic Nursing with Individual Patients and Nursing Therapy for Families. They may elect two more courses from the following:

Nursing in Focal Situations
Nursing Therapy in Group Situations
Community Mental Health Nursing
Nursing Intervention in Alcoholism and Other Drug Addictions
Psychopathology

Students majoring in medical-surgical nursing have two required courses: Medical-Surgical Nursing I and Medical-Surgical Nursing II. They may elect two more courses from the following:

Respiratory Nursing
Cardiovascular Nursing
Physical Assessment
Medical-Surgical Nursing Practicum

Students majoring in nursing service administration have three required courses: Nursing Administration I, Nursing Administration II, and Nursing Administration III. These courses reflect a total of 12 semester hours, and there are no optional courses. Students who are majoring in this area must plan with a time framework of at least 15 months (fall, spring, and fall).

Students who are majoring in a clinical area must minor in a functional area: teaching or nursing service administration. Six semester hours are required for a minor. There is a teaching practicum which includes learning experiences with nursing students in a baccalaureate or community college program. Each student is assigned to a preceptor (cooperating teacher) who assists the course instructor in evaluating the student's competency in teaching. The student must have completed Theoretical Foundations of Nursing and one clinical nursing course in order to enroll in a course which includes a teaching practicum.

Note: The preceptors must have at least 3 years of teaching experience. They must agree to serve as a preceptor and participate in the evaluation of the students' teaching competency. The coordinators of the Junior- and Senior- year levels must approve the selection of preceptors. The students select preceptors in their areas of clinical interest/major.

The curriculum pattern includes six hours of cognate courses. This requirement is congruent with the university requirement for all master's degrees. The cognate courses are outside of nursing, and students use these courses to enhance the focus of their study. For example, students who are majoring in medical-surgical nursing may wish to take courses in cardiovascular dynamics and/or advanced physiology. The students elect the courses, and faculty are expected to assist them in seeking courses that will provide additional breadth/depth to their areas of study.

Figure 1

Maternal Child Nursing Clinical Focus

	MPCH Faculty	*High Risk Perinatal*	*Family Health Consultant*
Required Courses	N392K Overview of MPCH N392L Conceptual Basis of MCPH Physical Assessment	N392K Overview N392L Concepts N392M.2 Counseling and Intervention in MPCH Disruptions N395 MPCH Practicum	N392K Overview of MPCH N392L Conceptual Basis of MPCH N392M.1 Preparation of Childbirth and Parent Educators
Optional MCH Courses	Choice of one: MCH Practicum or Disruptions or Childbirth and Parent Education	None	Choice of one: Disruptions or MCH Practicum or Physical Assessment
Minor	Teaching	Administration	Administration or Teaching
Elective	Open	*N395 High Risk Perinatal Nursing (replaces elective)	Open
Recommended Cognates and Electives	See list of courses on cultural diversity, ethnicity and rural health care; Educational Psychology; Clinical Teaching; Curriculum and Instruction	Reproductive Physiology Embryology	See list of courses on cultural diversity, ethnicity and rural health care; Health education; Sociology; Psychology

*New Course

There is an elective course within the no-thesis curriculum pattern. Once again, students have an option and most students select a course relevant to their major or minor area of study.

For all master's degrees at the University of Texas at Austin the thesis is optional. The faculty of the School of Nursing encourage students to elect a thesis; however, most students prefer the no-thesis program plan.

For students who select the thesis program plan there is some difference in the curriculum pattern. The course entitled Fundamentals of Research is the "a" part of the thesis course. Further, in place of the elective course the students take the "b" part of the thesis course. The total number of semester hours remains the same: 36.

The curriculum pattern includes a clinical practicum for the clinical courses identified in each area. Some of the courses in the functional areas of teaching and nursing service administration also have a practicum.

AN OVERVIEW OF A DOCTORAL MODAL CURRICULAR PATTERN

William Field

A modal program is one which we consider focuses on a sufficiently broad area to enable its graduates to function in a variety of settings. The degree program which the School of Nursing at the University of Texas at Austin opted for is the Doctor of Philosophy (Ph.D.) in nursing. This is a research-oriented degree and one of its primary purposes is to adequately prepare nurses to fulfill the need for nursing research to be done by nurses. The philosophy for our program includes:

> . . . Education in nursing prepares for a tripartite role of practice, function, and research, with emphasis changing progressively through the sequence of baccalaureate, master's and doctoral programs.
>
> Graduate education is built upon the development of professional knowledges, attitudes, and skills acquired in the first professional degree. Graduate nursing education prepares the nurse for advanced practice and role development.
>
> Graduate nursing curricula offer cognate courses from the biological, physical, and social sciences and the humanities which add the additional breadth and depth of knowledge necessary in advanced nursing practice and role development. Specialized nursing courses are offered in selected areas to enhance expertise in practice.
>
> The learning environment promotes collegial relationships with peers and students in other disciplines, and facilitates cooperative efforts that foster mutual student-faculty inquiry and function.
>
> The master's program, organized on concepts basic to nursing, offers students the opportunity to practice in selected learning experiences which afford familiarity with the clinical and role skills necessary to design, initiate, and execute high-level performance in collaborative roles with colleagues in nursing and other disciplines.
>
> The study of philosophies, theories, and research in nursing and related fields aids master's students in synthesizing a conceptual framework. Through the use of analytic procedures, students are capable of being actively involved in initiating change and contributing to the enhancement of nursing and health services. Through the acquisition of leadership qualities and strategies, the student is capable of promoting personal and professional growth, standards, and conduct.
>
> Doctoral preparation in nursing focuses on building the expertise necessary to make a significant contribution to the investigatory-research process and to knowledge development within the discipline, the profession, and the practice of nursing. The doctoral program prepares nurses to contribute to the augmentation of interdisciplinary and social intercourse.

This philosophy is built upon our undergraduate philosophy and is an extension of the master's program, which as Dr. Gallman has just told you focuses primarily on preparing a clinical specialist who is an expert practitioner. The objectives for our doctoral program are as follows:

1. assessing health needs which are relevant to the adaptive modes of individuals and society;
2. synthesizing current theories for nursing practice in relation to meeting the health needs of society;
3. conducting research and evaluation designed to advance knowledge in a specific realm of nursing and health care;
4. participating as a scholar in open and objective discussion of theoretical, conceptual and practical aspects of health care in the society;
5. analyzing the development of nursing from a scientific and humanistic perspective;
6. disseminating knowledge of "nursology" — the discipline, the profession, and the practice.

We view excellent components of the doctoral program to include not only research but also courses in theory, historical and philosophical development, and a functional role which will prepare for practice, teaching, consultation, and administration at a high level. From a sample program of the doctoral degree it may be seen that students have considerable flexibility in terms of courses which may be taken, while at the same time being required to take courses in a general area:

Required Courses	Semester Hours
Issues and problems in professional nursing	3
Theory development in nursing	3
Advanced research in nursing	3
Leadership roles in nursing (one in the series)	3
Historical study of nursing (one in the series)	3
Research methodology (one in the series)	3
Health care delivery	3
Total	21

Individualized Program	
Nursing major 12 semester hours	12
Cognate outside of nursing computer course advanced statistics advanced statistics	9
Supporting 9 semester hours in or out of nursing	9
Dissertation	6
Total	57

Required Courses in the Doctoral Curriculum

First let's look at the subject of research. All students are required to take an advanced research course in nursing. It involves advanced study and experience in research methodologies and design applied to conceptualization and conduct of studies in patient care and nursing education. This course is at a higher level than that required of all master's students.

Research Methodology

Topic 1. Critique of Research Design and Applications in Nursing.

Review and critique of existing evaluation models. Application of both research design and the models to theory-oriented problems.

Topic 2. Evaluation and Application of Computer Techniques to Nursing.

Use of computers in nursing care situations, nursing education, and research studies. Identification of useful programs readily adaptable to nursing problems.

Topic 3. Criterion-Referenced Measurement in Nursing.

Use of criterion-referenced measurement and clinical and classroom evaluation.

Topic 4. Development and Evaluation of Instruments Pertinent to Nursing.

Development of an instrument and evaluation of its properties.

Topic 5. Evaluation Models and Applications in Nursing.

Review, critique, and application of existing models to theory-oriented problems. Computer courses and advanced statistics courses.

Of the five courses under the heading entitled "Research Methodology," any one is required for all doctoral students.

Two core courses have been required of all doctoral students and cover the three portions of our qualifying exam. *Issues and Problems* involves an assessment of current issues and problems in relation to meeting health needs on all levels, the relevance to current nursing theories, the need for new theories in nursing, the development and evaluation of nursing problems to meet the health needs of society. The second core course is *Theory Development in Nursing*, an introduction to the nature of scientific explanation and inquiry. Critique of theory and conceptualization in nursing is included, as is examination of strategies for theory development. This, of course, includes analysis of the role of theory in nursing as a practice discipline.

These two courses plus the advanced research course are taken by students early in the program. Upon completion of these courses the student is eligible to take the qualifying exam. Another required course is *Historical and Philosophical Study of Nursing*. This course has three sections, any one of which may fulfill this requirement in the curriculum:

Topic 1. Philosophical Aspects of Nursing.

This section involves introduction to the analysis of nursing language: defining terms, detecting logical fallacies, analyzing meanings, and recognizing descriptive and normative aspects of judgments.

Topic 2. Historical Development of Nursing.

An in-depth study of the history of nursing with special focus on the influences and changes which have occurred within the profession. Review of the association of nursing with related disciplines, its emergence into institutions of higher learning, organizational structure and hierarchy, changes in educational focus due to preparation of educational leaders, and related topics.

Topic 3. Philosophy of Nursing Theory.

This is an advanced seminar in which applications to philosophical aspects of theory are made.

The other required course is entitled *Health Care Delivery*. In it students study delivery systems,

economic and political aspects related to the delivery of health care services, and their implications for nursing.

A final area in which we wish to prepare students in our program is that of leadership roles in nursing. Students may take one of three courses in this area.

Topic 1. Administration of Educational Programs.
Advanced study of the theory and practice of internal and external administration relative to faculty, student evaluation, accreditation, public relations in various types of programs as affected by controlling bodies, and the organization and purposes of nursing program.

Topic 2. Administration of Patient Service Agencies.
Focuses on the study of the development of health care services. It is designed to meet the needs and career goals of individual students.

Topic 3. Consultation to Educational and Service Agencies.
Principles of consultation; role of consultant; gathering, organizing, and analyzing data from consultative situation; and prescriptive modes.

This, then, is an overview of the required courses for the doctoral level: one in advanced research, one in theory development, one in issues and problems, one in leadership roles, one in the historical and philosophical study of nursing, one in research methodology, and one in health care delivery.

Individualized Programs

We now go to the individualized program. We have five majors in our nursing program: psychiatric-mental health nursing, adult health nursing, maternal-child nursing, research, and educational administration.

In the area of adult health, students have four courses:

Topic 1. Seminar in Adult Health.
This is an advanced seminar focusing on implementation of approaches aimed at solution of problems in the care of adults through the use of consultation and community, regional, or national action.

Topic 2. Special Problems of Adult Health.
An advanced seminar dealing with focal problems of interest to the student and faculty member teaching the course.

Topic 3. Special Health Problems in Aging.
Focuses on research findings and clinical data applied to the biological, psychological, social, and linguistic alterations occurring in aging individuals. Fieldwork with aging patients in a variety of settings — hospitals, extended care facilities, old-age homes, retirement communities — is included.

Topic 4. Comparative Health Care of the Aged.
Focuses on analysis of approaches to care of the aged in different regions of the United States and in other countries. Effects of socioeconomic level, cultural background, and technological and developing economies upon care of the elderly, and innovations in gerontological nursing are included. Also included are identifications of resources needed to effect change in health care of the aged.

In our major in psychiatric-mental health nursing, students are required to have 12 hours, but they may select from nine courses, including:

Psychiatric-Mental Health Nursing

Topic 1. Motivational Problems Related to Illness and Therapy.
Advanced study of motivational factors relating to progression or retardation of psychopathology and enhancement or hindrance of therapy. Practicum directed toward operationalizing nursing therapy in relation to motivational support.

Topic 2. Individual Therapy Adaptations to Group and Systems Therapy.
Advanced practice development focused on applying principles and techniques of individual therapy to varied groups and systems.

Topic 3. Milieu Therapy.
Advanced theory building and practice development directed toward operationalizing therapy principles to routine nursing care.

Topic 4. Nursing Therapy Development from Non-Sullivanian Theories.
Advanced study and practice development directed toward making operational nursing therapies from theories comparable to those of Sullivan.

Topic 5. Preventive Psychiatric-Mental Health Nursing.
Advanced development of direct prevention or intervention techniques to minimize the production of psychopathology.

Topic 6. Nursing Therapy and Development Related to Infants and Preschoolers.

Topic 7. Nursing Therapy and Development Related to Late Childhood and Adolescence.

Topic 8. Psychopathology.

Topic 9. Special Health Problems in Aging

You will note that the last topic is one from the adult health major. In this course we co-mingle the psychiatric and adult health majors to the mutual benefit of both. These last three courses were recently added to our program primarily for the purpose of meeting National Institute of Mental Health criteria.

The third clinical area in which students may major is that of maternal-child nursing. Again students are required to have 12 semester hours in this area and they may select from six courses:

Adaptation to Parenthood. Psychosocial adaptation of new parents. Maternal adaptation emphasized. Focuses on psychological and behavioral adaptation of parents, prenatally and postnatally. Reviews research on parental adaptation.

Primary Health Services. Seminar and experiences in providing primary health services to clients in the reproductive and caretaking periods.

Maternal Parent-Child Nursing.

Topic 1. Seminar on Parenthood and Family Life.

Advanced seminar on theory and research related to parenthood and family life.

Topic 2. Seminar in Child Health Nursing.

Focus is on implementation of approaches aimed at solution of problems in the care of children through the use of consultation, interdisciplinary collaboration, and community, regional, or national action.

Topic 3. Working Parents.

Psychological and social aspects of multiple roles. Advanced seminar focusing on occupational and parental roles and the resultant roles, strains and conflicts.

Topic 4. Predictive and Interventive Research with Families.

Advanced seminar reviewing, critiquing, and applying predictive and interventive research studies.

The fourth area in which students may major is that of nursing education administration. The courses in this major may be selected from the following:

Administration of Educational Programs. Advanced study of the theory and practice of internal and external administration relative to faculty, students, evaluation, accreditation, public relations in various types of programs as affected by controlling body, and organization and purposes of the program.

Practicum for Administration of Educational Programs.

Legal and Leadership Responsibilities in Nursing. Comprehensive study of laws which affect nurses and nursing, and methods for dealing with governmental agencies for the benefit of society and nursing. Practicum with professional associations or federal, state, or local governmental agencies as they are involved in making decisions affecting health care of people within a transcultural society.

Seminar on Nursing Education. Advanced seminar focusing on study of problems and issues in curriculum and teaching relevant to content, organization and planning in nursing programs in colleges and universities.

Students may major in research methodology. These courses are those which I presented earlier, from which students select one of the group of required courses.

Finally, we have the cognate courses and the supporting courses explained.

I hope this has given you a sufficient overview of what we regard to be not only a modal but a model doctoral program in nursing.

NURSING THEORY AND PRACTICE: A PHILOSOPHICAL DEBATE

Kathleen Goldblatt

The purpose of this presentation is to propose ideas and philosophical positions concerning the "should be" content for nursing practice within master's and doctoral curricula. My thinking is strongly influenced by my preparation in curriculum development and my philosophical position with respect to two areas relevant to the nature of nursing as a discipline and to the nature of theory.

Curriculum development as a field of study incorporates a process which guides program design and revision. Accordingly, it is necessary in identifying content for any educational program, at any level, to go about the business of re-looking at the philosophy, framework, and program aims as goals and objectives in light of new knowledge and evolution of a discipline. The philosophical statement and framework, whether conceptual and/or theoretical, should articulate the discipline perspective and syntax. Therefore, a precursor issue to selection of content is that of discipline perspective and syntax.

My philosophical biases related to the nature of nursing and theory will be considered by some to be heretical thinking but they influence, without apologies, structure for selection of graduate curricular content requisite for practice. Specifically, I believe there exists at this time *science in nursing*, not *nursing science*, and conceptual frameworks for practice, as well as theories from other disciplines useful for guiding nursing practice, but not *nursing theory*. Given this ideology, it seems necessary to explicate parameters one could use to select content for master's and doctoral curricula with the goal of contributing to the practice discipline of nursing today and preparing for the future.

The issue of discipline perspective and syntax is essential in defining the clinical content of nursing. In reviewing the literature, more commonality than divergence emerges. Donaldson (1979) proposes that:

> Each discipline is a distinct body of knowledge that evolved from a characteristic perspective or way of viewing phenomena. It is not utilization of scientific or any other particular methodology or the object of inquiry that characterizes a discipline; rather, the uniqueness of each stems from its perspective and syntax (p. 4).

Accordingly, she suggests that the discipline of nursing evolved from a unique perspective of viewing phenomena in terms of wholeness or health of humans as related to interactions with their environment. Further supporting this view, Donaldson cites works of scientific inquiry which are consistent with concern with principles and laws governing life processes, well being, and optimum functioning of human beings who are sick or well (Nightingale, 1860; Rogers, 1970); and concern with patterning of human behavior in interaction with their environment in critical life situations (Johnson, D.E., 1961; Rogers, 1970). Donaldson (1979) not only attributes the uniqueness of nursing as a discipline to concern with holistic man in interaction with the environment, but gives a sound rationale that the value system of nursing, derived from professional practice, sets nursing apart as a discipline. Again, quoting Donaldson (1979):

> Self-respect and self-determination of clients has been an integral part of nursing care. As a result of this value orientation, the discipline embodies and is structured by knowledge of humans as independent, self-determining systems in continuous interactions with and as influenced by their environments (p. 5).

Nurses generally have agreed on the central concepts which have been in nursing (Flasknud and Halloran, 1980). In the conceptualized role or practice of nursing, there is also more agreement than non-agreement. In her time, Florence Nightingale described nursing action as the provision of an environment conducive to healing and health promotion (Nightingale, 1860).

Other commonalities exist within the discipline which give structure or determinants for content selection. These areas of consensus are explicated through program aims. The dominant aim in graduate nursing education at the master's level is to prepare the nurse specialist or advanced generalist. The assumption is made that the master's curriculum is based on the first professional degree. Knowledge is reinterpreted, extended, and focused on advanced practice, inquiry, and functional roles. Specialization is usually defined according to target populations. The aim of doctoral programs in nursing varies at this time but ranges in a combination of nurse-scholar-researcher-clinician who may or may not be prepared for a functional role (Kelley, 1978).

Given the ideology of science in nursing and the absence of nursing theory, content selection parameters do exist based on the conceptual commonalities of the discipline and aims of graduate education. At the master's level, theories from other disciplines may be legitimately utilized to prepare

clinical specialists and advanced generalists. J. Johnson (1979) makes clear that ideas are not discipline-bound because "scientific knowledge by defintion is made available to the public; no group owns it" (p. 68).

J. Johnson further suggests that since students of nursing should learn to use scientific knowledge to guide their behavior as they practice, scientifically oriented, doctorally prepared nurses need to permeate the whole nursing educational system. Then, beginning students will be helped to identify how scientific knowledge contributes to the knowledge base they are acquiring, and they can be assisted to identify the need for more knowledge about specific phenomena (J. Johnson, 1979).

Regardless of the practice setting, target population, or the role dimensions, i.e. clinician, consultant, researcher, teacher, or administrator, if knowledge from another discipline is relevant to the problem upon which an individual is working, he or she has free access to that knowledge, and the usefulness of the knowledge is determined by the person's ability to recognize how the pieces of the puzzle fit. However, those who claim nursing as their discipline have the burden to make clear the connection between the problem upon which they are working and the domain of nursing.

Content *is* knowledge. Frameworks that do not emphasize existing scientific knowledge fail to guide students to exploit existing resources. Although process, technologies, and skills are important, these are not *the goal* but only a *means* to achieve a goal (J. Johnson, 1979).

Beare, Daniel, Gover, Gray, Lancaster and Sloan (1980), researching "the real versus ideal content in master's curricula in nursing," ponder the discrepancy between what educators teach and what they think should be taught. The high ranking ideal content items included change theory, communication therapy, group dynamics, legislative issues, research methodology, and ethics in nursing. These content areas seem to me to be commensurate with the emerging perspective of the discipline of nursing. Further, these researchers show that the findings of their study support the need for research to predict and document models for practice. Perhaps, faculty are rethinking because (1) the master's degree is no longer the terminal degree, (2) more doctorally prepared faculty are permeating the nursing educational system, and, (3) health care systems of which the nurse and client are a part are, indeed, an environmental variable.

The selection of content for clinical preparation at the doctoral level is more difficult than at the master's level because of the variability of program aims. However, the majority of doctoral programs in nursing have as a goal to contribute knowledge to the discipline and, as a practice discipline, the contribution ultimately will lead to a refinement of the structure of the discipline which in turn affects the refinement of practice. Until nursing science and nursing theories "come to be," the discipline perspective as we know it today and individual program aims must serve as content selection parameters. For those faculty who believe nursing theories exist at a level to provide substantive knowledge, content selection may not be as problematic. However, for those who are in philosophical agreement that nursing theories are not yet developed, the theory development system proposed by Chin (1978) may assist in providing a structure for curricular sequence and continuity. In order to appreciate Chin's theory development system, her definition of theory needs to be offered. She defines theory as ". . . an internally consistent body of rational statements about phenomena which is useful for prediction and control" (p. 2). Further, she declares, ". . . statements that provide descriptions and explanations of phenomena or that have undeveloped potential for control untested in a laboratory or natural setting, may be labeled 'conceptual frameworks' " (p. 2). Accordingly, Chin's theory development system includes the operations of:

1. Concept examination and analysis;
2. Formulation and validation of relational statements;
3. Theory construction;
4. Practical application of theory (p. 3).

As emphasized before, process is not viewed as content, but may be used as a curricular strand for sequence and continuity. Nursing curricula designed or revised in light of the aforementioned parameters will be ever-changing as the discipline evolves. Commonalities are necessary in the evolving discipline of nursing, yet diversity may exist in the chosen arena of practice.

In summary, the "should be" content is dependent upon many variables and will change over time. The perspective and syntax of the discipline of nursing seem to be emerging. Literature supports the contention that viewing phenomena in terms of wholeness or health of humans as related to interactions with their environment is the domain of nursing. Donaldson (1979) suggests that Dr. Kathryn Barnard has aptly described the nature of nursing as "Human Health Ecology." If we, in nursing, are all dealing with dynamic phenomena, the content requisite for "dealing" must also reflect change.

ESSENTIAL CONTENT: NURSING THEORY AND RESEARCH

Nita W. Davidson

The purpose of this presentation is to address the content of theory and research in graduate education in nursing. I wish to address the content area of nursing theory and research from the point of view of cognitive theory — specifically Piagetian theory — and I address content for theory and research as the object of knowing. For the purpose of this paper, the term *knowledge* will mean development of cognitive structure, which differs from knowledge as referred to in the 1.0 level of the taxonomy of educational objectives (Bloom, 1956). *Development of knowing* will be referred to as the stage of development of internal representation and mental activity for solving problems, and will be described as preoperational, concrete operational, or formal operational (Piaget, 1970). As you recall, reasoning at the *preoperational* stage of development may be characterized as transductive, syncretic, or juxtapositional, and the elements of what is known are in one-to-one relationship. At the preoperational level, one frequently knows "just because." At the *concrete* operational level, one reasons inductively, can consider a variety of elements simultaneously; however, may relate some but not all of the elements. At the concrete level, one reasons in relation to what is present, concrete, or believed to be present and can reverse or undo what has occurred mentally. At the concrete level one reasons through the use of maybe's — maybe this or maybe that will result.

At the *formal* level of development, reasoning is described as deductive. The person can consider the effects of all elements acting on or within a phenomenon. Reasoning is hypothetico-deductive and focus is on probability and possibility. Reasoning is reflected in statements of *if . . . then:* "If this occurs — then the outcome will be . . .," and reasoning can be related to the abstract.

For the purpose of this presentation, *theory* will be defined according to Kerlinger (1973) as a set of interrelated concepts/constructs, definitions, and propositions that present a systematic view of phenomena by specifying relationships among variables for the purpose of explaining, predicting or prescribing. Theory will be thought of as neither good nor bad but as evaluated according to measurement against a variety of criteria.

Research will be defined according to Kerlinger's (1973) definition, which is "systematic, controlled, empirical, and critical investigation of hypothetical propositions about the presumed relations among natural phenomena." Thus research is more than immediate problem-solving, since the goal of research is to provide an additional dimension to truth.

Theory and research are more than the double helix described by Fawcett (1978). Theory and research are only two strands of a triple helix, because there is an additional strand of practice. The mnemonic of this helix is not new to nurses — it is the TPR helix.

T-Theory is that which directs and gives order and logic to our research, and is a goal for the purpose of understanding nursing. Theory is closely associated with research in that the life of theory is a consequence of the results of research.

P-Practice is the backbone or reason for existence of nursing. Practice provides the feedback for theory and is the source of ideas for research as well as the setting for application of ideas resulting from research.

R-Research provides the knowledge base for the practice of nursing, and it is through research that theory is developed for the purpose of describing, explaining, or predicting phenomena associated with practice.

Strand	Area and Action	
Theory	► *Practice* guidance	*Research* directs
Practice	► *Theory* feedback	*Research* ideas
Research	► *Practice* knowledge	*Theory* life

There are several questions related to theory and research which have been addressed by faculty. One question has been "When should nursing students be involved in research and theory?" Another question is "What content should be included in the area of research and theory?" However, a prior question might be "What can be done to encourage and facilitate the *interrelationship* of theory-practice-research among faculty, students, and practitioners?" It is not unusual for students to report that they have had one or two courses in or related to research. Nurses teach the "how to" of research — that is, a course in methods of research and statistics where the content of nursing is often deleted or left to be addressed in other courses. The method becomes detached from the purpose, so that the process of developing knowledge and the use of knowledge to solve problems become lost in the myriad of details of "how to." The faculty and students center on "how to" and lose sight of the concept of why and for what purpose. The conduct of

research involves a process — a process not all that dissimilar to the process used in any deliberate decision-making activity. However, the goal of research process is different from the goal of nursing process.

A basic characteristic of research is that it is common to all disciplines in that the process has common elements and the product contributes to public truth. Students in nursing need to be introduced to theory and research at the same time they are introduced to nursing. It seems untimely for research or theory to be introduced in nursing as a course at the upper division level if students are to use theory and research to guide practice.

There are some concepts related to research which should be constructed very early by students in nursing. I would propose that as soon as possible, preferably prior to graduate education, nurses should have a structure for knowing:

1. The difference between problem-solving and research;
2. Statistical vs. substantive significance;
3. Concept of statistical power;
4. Descriptive vs. inferential statistics;
5. Concept of error in decision-making; and
6. Purpose of theory.

Nurses seem to have a high need for structure and predictability. Only in recent times has it been acceptable for the nurse or the patient to know about illness care. Nurses have not always been recruited into nursing because of their high need to know. I would propose that theory and research will become stronger strands in the helix of the discipline of nursing if we not only have nurses with a high need to know but reward those who question the rationale for actions.

At this time nursing has a paucity of theory. Theories most used in and by nurses are from other disciplines, and for this we need not apologize. However, there is more to nursing than application of theories from other disciplines. In nursing we need practitioners, researchers, and theorists — all of whom relate to each other and understand each other, but not all nurses must be equally productive in all three dimensions.

For additional comments on *content* in research in nursing, I would like to refer you to the ideas posed by Dr. Fleming in the January-February 1980 issue of the *Nurse Educator*. Moreover, because graduate education is based on undergraduate work, one should consider baccalaureate content in research and theory. For the baccalaureate student, I would recommend that introduction to theory and research begin simultaneously with practice, since research should be viewed as a means for providing the theory and knowledge base for practice.

From review of the literature it appears that the baccalaureate student should be able to:

1. Identify and isolate elements in the research process;
2. Follow a problem-solving pattern to arrive at a decision.

For the baccalaureate student:

3. Research and theory should be focused on as a source of knowledge for practice and conveyed through social interactons of discussion, reading, lectures, and experiences;
4. Ethics of research should be known as a subelement of the ethics of professional practice.

The baccalaureate prepared nurse is a consumer of research and theory, poses questions which need study, and, through understanding of the elements of research, collaborates with others in research activity. The baccalaureate nurse should be able to work with selected variables of daily clinical problems.

The baccalaureate graduate should be supplied with the rules of a conceptual framework for practice and be one who reasons at the preoperational-concrete transitional level of development in relation to knowing research and theory.

For research content at the master's level, I again refer you to the article by Dr. Fleming (1980) and further suggest that students should be able to reason at the concrete operational level or higher where they can:

1. Consider a wider range and interrelate a greater number of variables in identification of research problems;
2. Interrelate selected elements of practice-theory-research;
3. Prepare and implement a plan for conducting a research study in the area of speciality; and
4. Evaluate selected elements of a research project.

The general areas in research for which specific content seems essential to bring about concrete level of knowing would seem to be:

1. Overview of the research process and the interrelation of the elements;
2. Formulation of a research proposal from problem identification through methodology;
3. Analysis and interpretation of data which would be reflected in the conclusions and recommendations; and
4. Preparation of a written report of the research.

The identification of content for research and theory at the doctoral level is somewhat difficult because program aims differ. In the traditional Ph.D. program, research is the dominant focus of the program of studies, whereas in the professional doctorate, the D.S.N., both practice and research have high priorities. Whatever the nature of the program, a significant goal is to contribute knowledge to the discipline; therefore, *process* and *content* at the formal operational level are important.

There is much information available on theory-building, but little on actual theory in nursing. Theory development is circular in nature and requires both research and practice. Theory development at the doctoral level involves examination of concepts, testing of relational statements, and organization of statements for generation of a relational whole.

During enrollment in a doctoral program one should not expect extensive theory development. Theory development generally requires more time and research than that completed during doctoral study and generally follows attainment of the doctorate.

Chin (1978) reported that the process of developing theory, and not a specific outcome, should be emphasized in doctoral study. It is important that all theory-building activities in nursing be cemented by common concepts other than process. Moreover, it is doubtful that the common activities for nursing theory development should be, or even can be, agreed upon at present. Qualified persons should go ahead with scientific endeavors.

It is proposed that at the doctoral level the student should have an identified content specialty where a problem can be studied in a scientific manner. The student should be able to operate at the formal level of reasoning, that is:

1. Consider *all* possible variables which might act on the problem;
2. Read and critique research of others for the adequacy and logical consistency among all parts;
3. Propose research which reflects clarity, adequacy, and logical consistency among all elements;
4. Propose a method for getting the results of research into practice; and
5. Communicate the findings.

Wilson (1979) cautioned that in doctoral research faculty should be aware of the following: when the substantive structure of the discipline is vague and diffuse, the syntactical structure is overemphasized and the search for rules of form gains a function and importance that is out of proportion to the goal.

Recently conceptual frameworks have been identified which seem sound but have not been empirically tested. There is a real need for students at the master's and doctoral levels to evaluate or test the new frameworks as models for nursing. There is a need for scholars committed to the development of nursing knowledge.

In summary, theory and research must be an integral part of practice. Both process and content are important to the development of knowing nursing. One must begin to develop knowing of research, theory, and practice at time of entry into nursing and continue development of knowing if growth and refinement of the discipline of nursing are to occur.

FUNCTIONAL ROLES:

I. Clinical Nurse Specialist in Primary Health Care

Jo M. Jones

The definitive parameters for this educational process lie within the title of the presentation. We will be discussing master's level education for the Family/Community Health Nursing major. Let us begin with some commonly used definitions:

1. Primary Care — that level of care which emphasizes the provision of both first contact and continuing care. It is the component of the system that serves the majority of the population, most of whom are well; it is continuous, community-based, and is generally provided apart from and prior to inpatient care (American Nurses' Association/American Public Health Association definitions).

2. Community Health Nursing — a synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations (ANA).

The major objectivies of Community Health Nurses are the preservation and improvement of the health of a community. There are two major modes or roles which influence the education of the Clinical Nurse Specialist (CNS) in Primary Care:

1. *The Family/Community Health Nurse Specialist (FCH).* This mode of practice focuses on the community as client. The pattern of practice is to work with the community and its sub-groups to identify health needs and to motivate self-help in groups, set priorities for community health problems, determine nursing needs to meet the health requirements of the community, and evaluate the effects of existing nursing practice in the community setting. Knowledge required for specialized practice in community health includes community health nursing theory, public health sciences (epidemiology, biostatistics), theories of leadership and management, group dynamics, change theory, health policy planning, health politics, economics and marketing, community assessment techniques, and program planning.

2. *The Family Nurse Practitioner (FNP).* This mode of practice focuses on the patient and family as client. The FNP works with clients to assist in the attainment of optimal health and disease prevention. Direct patient and family care services include the assessment, diagnosis, management, and follow-up of *common* acute illnesses and *chronic* disease as well as the supervision of the well client. The FNP must also have knowledge of community resources and how common health problems of the individual impact on the community.

Graduate Education in Family-Community Health Nursing at Emory University

The Family-Community Health Clinical Nurse Specialist major is composed of two subspecialties: the Community Health Clinical Nurse Specialist (FCH), which is four quarters in length; and the Family Health Clinical Nurse Specialist with practitioner skills (FNP), which is five quarters in length. Throughout the program of study for both subspecialties, there is common core content, presented to both groups of students by means of common classes. Specialty content specific to each individual subspecialty is presented by means of separate clinical seminars. Courses in the clinical sequence for both subspecialties begin with physical assessment skills in the first quarter, and students are provided opportunities to develop further competence in these skills in subsequent quarters. (See figure 1 for Conceptual Process Model.)

In the second quarter the core class concepts of community organization and diagnosis, principles of epidemiology, the role of the Clinical Nurse Specialist in health care, and the family as a focus of nursing practice are introduced. This content is expanded in the core classes in the third and fourth quarters with emphasis on applicaton to different target populations. The focus of application is adult health in the second quarter, progressing to women's health, including pregnancy, in the third quarter, and ending in the fourth quarter with a focus on the needs of children.

Specialty content for the FCH students focuses upon community assessment and health planning within the framework of the nursing process applied to the community as the client. Students remain in a community setting for three quarters, working with community groups (provider and consumer) in the identification of community problems and in planning, implementing, and evaluating strategies to meet these problems.

Specialty content for the FNP students focuses upon the assessment and management of common, recurring health problems of the target population of study for each quarter. Utilizing a presenting symptom approach, students develop protocols as guidelines for practice. The fifth and final quarter of the program is a preceptorship in which students integrate and synthesize learning in an intensive clinical practice situation with a physician or certified nurse practitioner serving as preceptor.

Issues

Most of the issues confronting faculty involved in educating clinical nurse specialists for primary health care settings pertain to the family nurse practitioner role. Here are some of the issues. Perhaps we as nurse educators will have some of the answers.

1. **Understanding of the Role**

   Faculty outside of the major tend to oversimplify the role by equating physical assessment skills with the totality of skills required for the nurse practitioner role, thereby causing misunderstanding in regard to faculty effort in terms of teaching time required.

   Students tend to have at least a triple identity crisis, i.e. socialization to the role of a graduate student, socialization to advanced family community health nursing, and socialization to the role of family nurse practitioner.

   Physicians tend to misunderstand this role in a time when there is need for collaboration among health providers in primary care.

   Consumers tend to be unaware of the value of the nurse practitioner in providing primary health care (this will require much in the way of consumer education).

2. **The Educational Process**

   How much is enough knowledge in regard to pathophysiology, pharmacology, laboratory and x-ray procedures, emergency procedures, such as suturing, etc.?

   Faculty must reiterate the *Nurse* part of practitioner; we do not need additional medical triage workers out there in the primary care setting, we do need health care providers.

   Reduction in federal funding of nursing programs presents a problem.

3. **Multiple Levels of Preparation**

   Preparation is currently offered through certificate programs, master's programs, and on-the-job training.

   All take the same certifying examination.

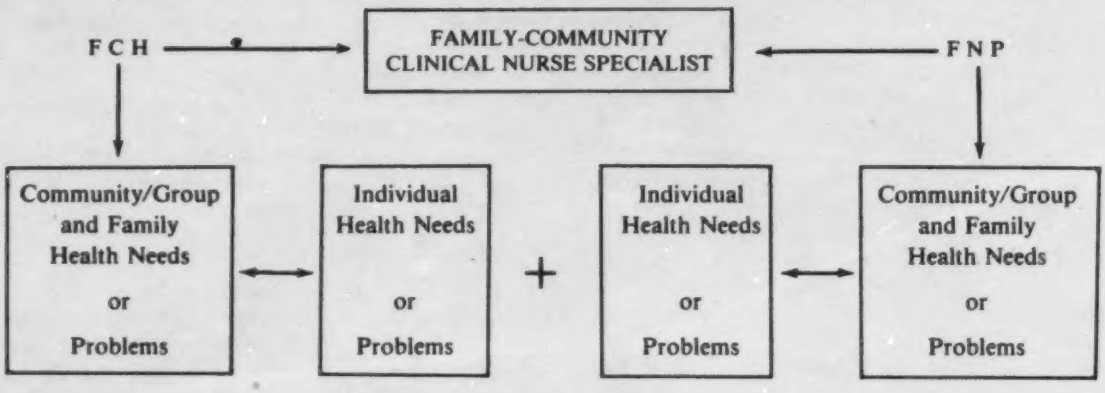
   Is there a difference in practice?

4. **Multiple Specialty Programs**

   Programs tend to follow the medical paradigm of specialization; tend to omit key core input, such as concepts of family and community; tend to further fragment patient care.

Figure 1

CONCEPTUAL PROCESS MODEL


F C H
FAMILY-COMMUNITY CLINICAL NURSE SPECIALIST
F N P
Community/Group and Family Health Needs or Problems
Individual Health Needs or Problems
+
Individual Health Needs or Problems
Community/Group and Family Health Needs or Problems

FUNCTIONAL ROLES:

II. Teaching

Myrtis J. Snowden

What are some of the issues surrounding the functional role of teaching in nursing and what directions might emerge in the future? According to Webster, *functional role* is a characteristic action that one displays or demonstrates as natural and proper for a setting or situation. The role of teaching nurses is a part of the development of nursing. Almost 50 years ago the Association of Medical Colleges complained that too few schools of nursing existed and that there were too few graduate nurses (*School and Society*, 1933). During that time a popular publication noted that almost a third of teachers of nurses had never completed high school, and that only two percent had one or more years of college (Watson, 1977). A few years later (1939), the National League of Nursing Education began accrediting schools of nursing. Subsequently, the National League for Nursing assumed the function of accrediting nursing education programs. It is curious to note that in the early years the accrediting agency did not appear to be overly concerned about teacher preparation.

The evolution of the teaching function in schools of nursing, in a curious way, parallels the evolution of nursing itself. Just as nursing began through apprenticeship training, nursing education began under a hierarchy of a matron, head nurses, and students. Lectures for the students were provided by doctors, and unit or ward nurses provided practical instruction in the "how to" aspects of patient care. The physician-lecture/nurse-show-them modality slowly evolved into nurses teaching nurses. Further, it is noted that early nursing education programs may have consisted of five years of preparation that included: two years of liberal arts, two years of hospital training, and one year of specialty in either public health nursing or teaching (Watson, 1977). Graduates of such programs received both a nursing diploma and a bachelor of science degree. Thus, precedent was set early that the teacher of nursing could be prepared at the baccalaureate level. While administrators employed teachers with baccalaureate degrees to teach nursing in college settings, nursing was already behind educationists.

Issues for consideration then are: When does the nurse educator learn what to teach, and where does the nurse educator learn how to teach? A search of the literature reveals a paucity of information on the use of, or benefits derived from, teachers of nursing using methodological approaches to teach aspiring nurses. In fact, teaching methodology research is scarce for all collegiate teaching. It appears that researchers have concentrated, for the most part, on teacher attitudes, student attitudes, teachers' assumption of roles, such as advising, conferring, steering, socializing, and supervising. Nursing, like education, has had problems related to stereotypical roles, female dominance, lack of autonomy, and a continuing struggle for professionalism. Unlike education, however, there is little evidence that nursing has dealt with method as an essential element in teacher qualifications. Historically, educationists saw teaching competence growing out of normal schools, and their graduates prepared to teach in secondary and elementary schools. Furthermore, doctoral education is generally regarded as preparation for teaching at the college level. Conversely, nursing has concentrated on the preparation of teachers at the master's level. For example, the graduate student is expected to transfer information cognitively from education courses into nursing curriculum and into nursing teacher practicum experiences as well. At the conclusion of such experiences the graduate is said to be functionally prepared to teach.

To function as a teacher of nursing, one cannot know what to teach unless one has mastery of the subject matter, and one cannot know how to teach unless one has a mastery of the technique. Hodenfield and Stinnett, addressing the education of teachers, stated:

> Without adequate numbers of inspiring well-informed teachers, fully prepared to meet their responsibilities in our schools, we cannot have good education, and without good education we cannot hope for long to meet successfully the challenges of a changing world (1961, p. 21).

Teachers, therefore, should have a broad knowledge of subjects, supplemented by a knowledge of the best methods. The teacher needs to have: 1) knowledge; 2) knowledge and method; and 3) knowledge, method, and doctrine. This sequence is considered important, for it does not necessarily follow that if you know your subject you can teach it effectively. Most nurse educators would agree that methods courses are essential for teachers, but not to the exclusion of courses in various subject matter fields which the future teacher may need. Without skill in teaching, student learning is less likely to occur.

There is little doubt that nursing leaders, including administrators, educators, and care providers, have disagreed over functions of nursing education. There is no doubt that disagreement over function is a major factor in disagreement over levels of nursing education, preparation of nurses, as well as over length and content of nursing education programs. The areas of disagreement, in turn, influence the content of the programs that prepare nurses for their roles as teachers.

Thus, what happens in teacher curricula is somewhat reminiscent of a mythical tale. Once upon a time, according to some of the most reliable sources of mythology, weary travelers in Eleusis used to stop at the house of Procrustes and ask for a night's lodging. Procrustes would show them to the guest room and measure them against the size of the bed. If the bed was too short, the guests were chopped down to size; if the bed was too long, the guests were stretched until they fit. In either case, the "fitting" usually was fatal. The question or issue at hand continues to be: Who is the teacher, what does he/she teach, where or at what level does he/she teach?

One writer states that at first the teacher was not differentiated from the scholar. Later, however, the teacher was differentiated from the scholar by method. That is, preparatory training for teaching was empirically based. Now, this writer urges that preparation for teaching be rational. It was further pointed out that, within the parameters of rational teacher preparation, method must be the outgrowth of known physiological, psychological, and ethical laws. In essence, the capable teacher must be a person of science in the same sense that a reputable biologist is a scientist. Teaching is no longer a trade, a calling, or an empirical art, but a rational art, an art deriving its inspiration from science and basing its practice on established laws. The writer goes on to point out that a science of education is beginning to emerge from the art of education (Payne, 1973).

Educationists who use the term *science* as distinguished from *art* describe science as a higher order of knowledge and art as a correlated but lower order of knowledge. Such a contrast depicts science as knowing and art as doing, or principles which art involves, and science evolves. This contrast can be compared to the concepts of theory and practice as in the theory and practice of teaching. That is, ideal teaching grows out of theory embodied in practice, or practice guided and inspired by theory. Thus, teaching would reflect the largest element in professional behavior, that of theoretical knowledge, moving away from the largest element in trades, practical knowledge (Payne, 1973).

Frontiers of Theory in Teacher Education in Nursing

The frontiers of theory in nursing education could conceivably build on the creative thought, knowledge of nursing, and knowledge of man that nurse educators possess. For example, there is a sufficient number of nurse educators who should pool their wealth of creative thought. Further, these thoughts should be gathered and organized. From such an exercise teachers should have sufficient wisdom to guide aspiring teachers. But it appears that those who guide teachers of nursing are unable to organize their wisdom and command the power to put such wisdom to work. There is sufficient knowledge of nursing and of teaching to design the content of a great teacher education program for nursing. But the teachers of nursing are, in many ways, bogged down in traditionalism or consumed by new gadgets. Moreover, there is sufficient knowledge of man, his behavior, and his needs to organize that which should be taught. Yet, teachers of teachers seem unable to cut through the maze of curriculum structure to grasp what the teacher needs to know to be an effective teacher.

The teacher of teachers must move from the strait-laced conformity of today to the creative paths of the educational system. In essence, there must be a realignment for teacher education. Basic to the realignment is preparation for: things a teacher must do; things a teacher must be; and things a teacher must know. Wilhelms (1970), in arguing for a change in the learning laboratory for teacher education, put forth two positions. His argument for teacher preparation appears to be relevant to realigning teacher preparation for nursing:

1. Any professional program which depends on a sequence leading from abstract, theoretical academic study of education to a final massive dose of experience is unusual and likely to be ineffective.
2. Any profession which finally delivers the student into the hands of one or two "master teachers" who are to show the student how to teach is not only unsound but also potentially damaging and this is true even if the master teachers are exceptionally skilled.

The first of these position statements is not unusual. The traditional "theory first-practice last" sequence is ineffective and has, for the most part, been discarded in learning the practice of nursing. Why such a traditional approach to teacher preparation is maintained at the graduate level is not understood. Could it be that masters' program curricula are too short and so intemperately crowded with content that teachers are reluctant or unable to appreciably alter the program or pattern of teacher preparation? Of course, more basic to the question is, should teachers of nursing be prepared at the master's level? Nevertheless, the "theory first-practice last" sequence is ineffective because real life experiences lag behind information presumably gained from textbooks and classroom sources. However, it is realized that the pattern for any curricula is supportive of the idea that subject mastery must be achieved before one begins to teach. But the question is raised again, If you know your subject, does it necessarily follow that you can teach it? It would appear that a satisfactory mix of knowledge base and method skill is needed. If time in school is an important factor, and most

people would agree that it is, then functional preparation for effectively teaching nursing probably belongs someplace along the educational ladder other than the master's level.

The second position statement criticizing the use of master teachers for novice teachers has received support from several educators. In fact, one educator considers such practice to be a disaster. More succinctly put, criticism of the use of the master teacher is not related to the qualities possessed by the master, but rather, criticism is directed toward that practice of delivering and forcing aspiring young professionals into situations where they are warped to fit somebody else's perceptions.

The use of the supervising teacher, a practice similar to the use of the master teacher, has also been criticized. Kline and Dale, for example (1975, p. 99), equate the supervisor of teachers as representing a system designed to do something to somebody. To these writers, "supervisor" connoted an outworn, more or less authoritarian, and certainly unaccountable arrangement. There is much indictment of the supervisory role for student teachers. Perhaps the most serious is that we often assume what supervision is, but in fact cannot agree on what it actually is or what it does. Furthermore, the efficacy of supervision as an educational role has been questioned. Masher and Purpel (1972) suggested that supervision is ineffective because we do not have an adequate theory of supervision, much less a theory of education around which supervision is to revolve. These writers stated:

> The difficulty in defining supervision in relation to education also stems, in large part, from unresolved theoretical problems about teaching. Quite simply, we lack sufficient understanding of the process of teaching. Our theories of learning are imprecise, and deep disagreement exists about what knowledge, that is, what curriculum, is most valuable to teach. There is no generally agreed-upon definition of what teaching is or how to measure its effects. The systematic improvement of instruction, and clarification of the place and practice of supervision in such improvement, must ultimately wait upon basic research on questions of this kind. When we have achieved more understanding of what and how to teach, and with what special effects on students, we will be much less vague about the supervision process (Masher and Purpel. 1972, p. 3).

Building on the Masher and Purpel thesis, Kline and Dale went several steps further and suggested that the title "clinical professor" replace, literally and figuratively, the titles "supervisor" and "master teacher." The "clinical professor" is perceived to be an analytic scholar, capable of designing and developing original methods and materials for curriculum and instruction, and of developing designs for pre- and in-service instruction of teachers. That is, the "clinical professor" has a calling, and it is the systematic and critical analysis of educational theory and practice in a participatory setting (Kline and Dale, 1975, p. 99).

In closing, issues and future directions relative to the role of teachers of nursing include, among others:

1. What is functional preparation for the role of teaching?
2. Where and when should teacher preparation occur?
3. Are traditional teacher preparation programs efficacious for today's nursing student?
4. What, how much, and when should the graduate student deal with subject matter of the doctrine and methods of teaching?
5. What innovative changes could conceivably be made in the teaching laboratory that would benefit the student teacher as well as the learner?
6. Where are the researchers who would deal with problems, curriculum, subject matter, method, and skills in teaching?

FUNCTIONAL ROLES:

III. Nursing Practice Administration

Lois C. Malkemes

The topic of nursing practice administration has created within me a sense of frustration in trying to articulate the issues and more frustration in outlining the abilities needed. I know what controversy looms within the literature when it comes to defining what "ought" to be the curriculum of programs preparing nursing administrators. I wish I could tell you at the onset that I have resolved the controversy and have ready answers. I do not! I do have a way of looking at the subject, which I will share with you for deliberation.

The central issue, I believe, is whether we prepare administrators for nursing service or nursing practice settings. This distinction may or may not be meaningful to you, but it has provided me with an important conceptualization and ultimate differentiation.

Although I will not go into great detail here (I have done so in a chapter in Norma Chaska's *The Nursing Profession*), the basic distinction is between professional practice and master-servant structures, those which provide a structure for autonomy and those which necessitate subordinate-superordinate relationships. It is quite clear that what we have now is a service setting, mandating the dependence of the worker on the super-structure. What I am suggesting is a structure that necessitates that the authority, autonomy, and accountability for care rendered the individual patient be at the grass roots level by the care-giver. Decisions must be made at the grass roots level for patient care and for the worker's own destiny.

So what, you say. Well, how we prepare administrators will be dependent on what we prepare them for, and I believe this differentiation is crucial for both professional nursing education and professional nursing practice. To reiterate, a professional nursing practice administrator is a professional nurse who has the responsibility for the development of a professional practice setting, where the professional nurse delivers care to patients with autonomy, authority, and accountability.

The professional practice setting differs from the traditional "service" setting, in that:

1. The accountability for care is at the grass roots level;
2. Incentives and rewards must be geared to clinical performance and excellence;
3. Governance of the organization needs to reflect representation of the workers;
4. Methods for procedures, such as documentation, must be congruent with the modality of care.

Having briefly described what I consider to be the central issue, let me then elicit the specific abilities of the practice administrator, and the framework within which they are undertaken.

It may seem absurd or trite, but in order to develop a practice setting, one must have a clinical nursing identity that allows conceptualization of the components of a professional practice and decisions to be made that impact on that professional practice. In addition, a sound clinical base will help validate professional education outcomes, an absolute necessity in the next decades. I know the pros and cons of the argument for and against a clinical component in the master's program in administration. I would say that theory without some practice is fruitless, since practice makes real that which one thinks and knows. The easy decisions will come easily. When the hard questions come, the administrator must know, in order to make those hard decisions. When it comes to decisions about practice, it is essential to know. Whatever the controversy is in your own mind, a strong clinical practice identity, developed through a socialization process that leads to strong clinical ties, is the basis for strong nursing practice administration.

Knowledge of complex organizations with experiences in analyzing those organizations will assist the administrator in being able to know the organization and establish priority lists for problem resolution. In addition, the nursing practice administrator must establish the mission, goals, and objectives of nursing in relation to the larger organization. A statement within that mission regarding professional nursing care gives us direction, but if knowledge of the organization does not support that structure, alternative goals and objectives must be established The knowledge of organizational functioning will help in identifying centers of influence, channels of communication, and pockets of authority. All of this is important to organizational functioning and planning. Ultimately, the nursing practice administrator must ask: "What do we want to accomplish, how, and within what framework?"

The administrator must know what resources, human and non-human, are necessary to carry out the mission, goals, objectives. The answer to this question is based upon a careful assessment of where you are, where you want to go, and within what time frame.

This is more than budgeting. It is programming, and involves manipulation of resources to achieve goals. The answer to these critical questions rests with the philosophy, goals, and objectives that have been established.

Given scarce resources, human (pool of professional personnel) and non-human (supplies and equipment), what decisions are to be made? If the philosophy is of practice, decisions will be made from the point of view of patient care, where the decision will intimately influence the basic goal of nursing practice. The decision for the allocation of scarce resources must also come from the philosophy and objectives of practice.

A very large part of working with human resources is the recognition that they are human, psycho-social-biological beings, personalities, citizens, and people who require motivation, participation, satisfaction, incentives, and rewards. The very recognition and value of the worker as human can help solve the multiplicity of problems that arise in the course of the administrator's day. Working with and through people consumes a large percentage of time. It involves problem-solving, as well as directing resources, in order to get the highest returns. The focus must be effectiveness, not just efficiency or cost.

Another critical responsibility of the practice administrator is that of assessing the organization, and planning for the future. What are the facts about the organization now, and what are its strengths, weaknesses, power centers, and goals? Then, the administrator must ask, How can I make immediate gains without endangering long-term benefits? Plans should be realistic within the framework of practice and problems identified should be solved within the framework of what it means now and the implications for the future. Cautious planning is essential for keeping the organization in dynamic equilibrium.

An administrator must have an awareness and appreciation of the impact of the formal organization on its environment and vice versa and on health care delivery in general. One is a professional and must know and understand the impact of professional issues and concerns. You will be, in part, responsible for solving the larger system problems, and yet continue to solve the microsystem problems of delivering care to people: not an easy job, but an essential one. How do you contribute? How do you negotiate? How do you compromise? All without losing sight of your mission.

Perhaps all of the foregoing sounds easy to accomplish, but I believe there must be at least four attitudes, with their associated values and corresponding behaviors, to help bring the foregoing expectations into fruition:

(1) **Achieving goals and objectives through others.**

Helping people achieve and consequently achieving through them is a significant part of the administrator's role. It sounds easy and all administrators will subscribe to it (like motherhood and apple pie), but it is so easy to be authoritative and just get the job done. Worse yet is to be permissive and authoritative, and consequently give double messages. The hardest time to work through people is when there are deadlines, yet we, as administrators, are teachers and developers, and we do our staff a favor by setting the parameters and the time frame and then letting people set their own limits and meet the expectation.

Working through people necessitates having the knowledge about what motivates people, what gives them satisfaction, and how to provide incentives and rewards. Nursing practice organizations will necessitate a different reward system, and thus will need a differing structure for its implementation. Governance systems can be helpful in establishing grass roots review and peer support. Working through others relates as well to the interdependence of the nursing administrator with other organization administrators — an absolute, so that the organization can function smoothly. Working together is essential, but not always achieved.

(2) **A framework and attitude of change is essential to move an organization of nursing practice from a traditional hierarchical mode to a decentralized, grass roots professional practice.**

The knowledge of planned change is essential and the opportunity to be a part of planned change, as a learner, is helpful. The attitude of risk-taking is crucial, as is the knowledge of when to take risks responsibly. Timing is a necessary strategy — when to step in, when to be instrumental, when to let events take their natural course, and when to hold tight during adversity when everyone is telling you to give in.

(3) **Recognize even the tiniest of rewards.**

If you get your rewards from extrinsic sanctions, you may have trouble with burnout. Rewards are small and infrequent. One must *know* one is on the right track, and it is this confidence and competence that are important in getting through the rough spots. Some satisfaction in helping to provide a professional practice setting will be the impetus to continue. As Earl Reum said, "I wish you could achieve some great good for mankind, but have nobody know about it, except for you."

(4) Approach the practice of nursing administration with a sense of inquiry.

There are many unanswered questions in nursing practice, and the practice administrator must set the tone for the staff to ask questions and for research to be carried out. There are many researchable questions from the administrator's point of view as well, and they deserve our attention.

How does one achieve this "wonder person" through an academic program? Selection and admission criteria must help to discriminate candidates. The curriculum, I believe, must address the development of a secure clinical nursing identity, and within the curriculum one must gain a working knowledge of complex organization, change, strategies for working through people, helping human resources achieve research, and planning for resources, immediately and futuristically. I think it can be done, and I have high hopes for the future of professional practice settings, with administrators who nurture them.

FUNCTIONAL ROLES:

IV. Research

Juanita W. Fleming

According to the National League for Nursing, one of the characteristics of graduate education in nursing includes the acquisition of skills and competence in research (National League for Nursing, 1979). The American Nurses' Association statement on Graduate Education in Nursing (1969) indicates that the major purpose of graduate education in nursing should be the preparation of nurses capable of improving nursing care through the advancement of nursing theory and science. Incorporated in that statement, research seems implied.

It seems that regardless of the functional role assumed by the individual who completes a graduate program in nursing, systematic inquiry should be an aspect of the preparation. The increasing complexity of the health care system and the shift of nursing education from hospital-based schools of nursing to colleges and universities, as well as the increased number of graduate programs, has promulgated the development of research on nursing care. Consequently, all nurses should appreciate the importance of the contribution of research to the improvement of nursing care.

In setting priorities for the 1980s, the Commission on Nursing Research noted that, "The profession of nursing is vitally concerned with maximizing its contributions to the promotion and maintenance of the nation's health. Recognizing that the full potential of nursing's contribution to health care is contingent on a scientific basis for clinical practice, increasing attention is being directed to generating new knowledge through research and to mechanisms for ensuring its use in practice" (American Nurses' Association, 1980).

There are several definitions of nursing research. One is that it develops knowledge about health and the promotion of health over the full life span (American Nurses' Association, 1980). Concern is with the care of persons with health problems and disabilities, and with modalities to improve the quality of life for them and other individuals regardless of health state. Gortner (1975) distinguishes between nursing-research and research in nursing by indicating the first has as its subject the care process and the problems that are encountered in the practice of nursing: maintenance of hygiene, rest, sleep, nutrition, relief from pain or discomfort, counseling, health education, and rehabilitation. The second has as its subject the profession itself, its practitioners, and the characteristics of their practices: utilization, costs, administration, career patterns, educational level of nurses and nurse students. It is my belief that only nurses can do that research which Gortner calls nursing research, as it is the "life blood" of the discipline.

Since master's education is usually designed to prepare specialists in a particular area, research content is desirable. It's uncanny that Dr. Davidson would utilize Piaget as a model for presenting cognitive skills in research and theory, and would also utilize my article "Teaching Nursing Research Content," as I, too, wished to make some comments in these areas. So as not to repeat some of the things mentioned by Dr. Davidson, I have changed some of my presentation. In reviewing an article in the September 29, 1980, *Chronicle of Higher Education* on Piagetian-based instruction in thinking of research as a functional area, one could substitute the instruction model for a research model. Piaget-based instruction facilitates communication, improves reasoning abilities, boosts self-confidence and interest in work, and provides a practical basis for integrating different subjects in a curriculum through common emphasis on cognitive skills. Each of these seems to me to reiterate skills which research also promotes. Further, the validation of nursing practice is enhanced through research. Using the Piagetian notion of reasoning hypothetically enhances the consideration of the effects of different variables and possibilities which may need to be tested.

Notter (1975) spoke of the paucity of research in nursing. In the early 70s, it was noted that most research in nursing which was done by nurses was that which was done by master's prepared nurses. These were master's theses and studies done as a part of the master's degree. I don't know where we are today in that regard. However, based on a preliminary report of the analysis of data for the nurse doctorate study (designed to identify factors associated with professional productivity), it appears many doctorally prepared nurses, including those with the Ph.D. degree, which is considered the research-oriented degree, are not presently engaged in research nor have they done any other than that required for the doctoral degree. There are many reasons for this, some of which we could spend time discussing. Since that is not the topic on which I was to speak, and the study report is not yet final, no further comment regarding this issue will be made.

Though we may have more research because of the increase of doctoral programs in nursing, the largest number of studies are still probably done by master's prepared nurses as a part of studies for the master's degree. Despite problems, research activity increases in nursing schools. This is said to be due to the shift of nursing education from hospital-based schools of nursing to colleges and universities and the growing number of graduate nursing programs, as well as the increasingly complex health care system spurring on the

development of research on nursing care (*Chronicle of Higher Education*, November 10, 1980).

The functional role of research for those prepared at the master's level seems to be basically a nonentity. First of all, many students will not opt for research *per se* as a role at this level, though many engage in research activity as a requirement to obtain the degree. Since research is included as a part of what most students must do at the master's level, some students have as much of it as they can take. Those interested in research realize that after graduation, for the most part, there are not specific roles they can assume, except as research assistants on the projects of more senior individuals. When preparing for a leadership role in nursing, a position as research assistant does not necessarily promote that image. Too, research assistant positions are viewed as a temporary role, generally.

Some master's programs that had functional roles, such as beginning nurse researcher, are giving them up. The aim was to encourage a strong research basis for doctoral study. Opportunities to do this by integrating research throughout the curriculum and requiring conduct of studies seem to have solved that problem. Further, opportunities to participate in research in roles as research assistants while pursuing master's, as well as doctoral work, is possible. The research assistant role for nurses facilitates development of research but is not viewed as a position for which one prepares professionally.

Preparing for a functional role of research at the doctoral level is another challenge. The science of nursing is very complex. I agree with Dr. Davidson's emphasis on the importance of theory development. Just knowing research alone is not enough. A content base is also essential. One has to have something to study. A content area in nursing or which can relate to nursing, as well as research expertise, is critical in developing a role in research at the doctoral level.

As a result of varied experiences related to research — research consultations, serving on review panels, and research advisory committees — I have concluded that nurses have no difficulty identifying many worthwhile problems for study. There are a multiplicity of problems for study — basic problems, applied problems, studies about clinical phenomena, as well as about the profession itself. The difficulty that seems most evident is conceptualizing those problems and methodological considerations in handling them. The clinical phenomena that nurse scholars attempt to study are sorely in need of valid and reliable instruments which will aid in measuring the phenomena more precisely.

Once research is done we need replicated studies which will aid our generalizing to larger population groups. We need skills in effectively communicating our findings to lay and professional audiences. We need nurse researchers who can work with other disciplines and collaborate with them on the study of particular phenomena. Downs (1978) notes that in order to facilitate the pragmatics of theory building and testing, we need to enhance the communication systems among the various centers that are actively pursuing the search for knowledge. Grantsmanship skills are needed. Utilization of computers is a must because we are in, or are rapidly moving to, a computer age. Nurse researchers to serve as mentors for developing researchers are also essential.

With the financial exigencies being experienced in our society, there is likely to be increased difficulty in justifying a strict or sole role as researcher. It is noted, however, that nurse researchers are available in more progressive hospitals. The Veterans Administration Hospitals' Nursing Service, for example, has such a role, as do some other institutions. Research nurses can be also found in some state and federal govenmental agencies. A few may be with private foundations and some with universities in research-designed chairs or in research-titled series (which usually carry no tenure). Those who hold positions in these non-tenured series are expected to generate salary support through grants. Without grants there are no positions. I am afraid, though, that many of these nurses may get caught in areas where administrators need dollars for other areas and will ask them to serve in other capacities. Since most nursing research will likely be done in universities, many nurse researchers will combine a teaching/research role. Frankly, this is probably the role most nurses who engage in research have at this time.

Certainly, research as a functional role is not only desirable, but essential for two profound reasons. First, the complexity of the discipline of nursing and sparsity of research activity is a critical concern. Second, accountability to the public for the human use of nursing knowledge in providing effective and high quality nursing services is the hallmark of the profession. Consequently, regardless of financial exigencies and other considerations that affect the promotion of a role in research, some nurses dedicated to the role must be prepared to assure the ongoing development of knowledge for use in the practice of nursing.

Finally, though I believe nurses who conduct research are needed, I also firmly believe that all nurses should be curious and have inquiring minds. I believe all nurses must appreciate research. Therefore, we should definitely start at the baccalaureate level encouraging hypothetical reasoning if, indeed, we hope to produce a cadre of nurses who will enable us to provide excellent tested nursing care to the public we serve.

FUNCTIONAL ROLES:

V. Organizations

Ruth Q. Seigler

It is a pleasure to share with you some thoughts on issues and future directions in graduate education for nurses from my perspective as a "typical bureaucrat" in state government. I was given that title in a recent legislative hearing for "sunset" review by one of the panel members.

It is my charge to address the functional roles of "negotiator" as defined in the SREB curriculum project. A *negotiator* is a nurse in such leadership positions as officer in the state association, administrator of an organization, or policymaker in the state or nation.

I have a very strong bias that every nurse involved in any nursing program at the graduate level must have academic preparation directed toward socialization of that nurse as a leader and a negotiator. The nurse must recognize that she has a new role identity in which she demonstrates independence, knowledgeable decision-making, and accountability. In order to have a significant impact on health care we must incorporate methods to facilitate change. A broader knowledge base and additional health assessment skills gained in a master's program in nursing will not suffice to meet the definition of the functional role "negotiator." A firm foundation that asserts, "I know what my role is, I know what my responsibilities are, and I know how to accomplish them," must be built into graduate nursing education regardless of the purported outcome of clinical nurse specialist, teacher, or administrator.

There are core courses that are essential for graduate education, such as courses in management, leadership, organizational skills, research, nursing theory, and legal and ethical issues. There can be specialization or generalist tracks beyond these based on the particular program.

Educators in graduate education in nursing need to be excited and enthusiastic. They need to be motivated to motivate. They need to recognize their tremendous opportunity to shape the future with their living contributions through their product. What a tremendous opportunity is the educator's! You must look beyond a dry, well-prepared, five-year-old lecture to dynamic, real-life here-and-now and to the future. It's like the nurse who rescued a person from the river, resuscitated him, and then another and then another, and she was so busy repeating the act that she never had time to go up-stream to assess the problem and redirect her time and energy to meeting the need.

In this new decade you cannot be strapped to old stereotypes; you must be risk-takers. You must commit to continue your effort of moving nursing into the mainstream of contemporary society. Certainly under our new conservative presidency the emphasis will not be on new development but on recycling our current resources. Nursing education and nursing practice stand on the threshold of dynamic change. Now is the time to come forward with leaders in all areas of nursing who know how to negotiate, who understand systems, who know when and how to compromise or when to stand firm.

The questions of mobility, accessibility, and availability that you are addressing in tomorrow's program are keys to the viability of your future and mine. In this time of widespread concern regarding the nursing shortage, the up-front money is going to undergraduate programs, but some of the unaddressed issues are: Why do we have our severe retention problems? What is the role of the employer and the educator? Do we need more negotiators? Do we need leaders who know how to market the product?

We must be visionary! We must be open, creative, and even vulnerable. Now more than ever before we must come together and cooperate. There will be some conflict, some compromise, and some change. But most important there must be commitment to some common goals.

To quote from the spring 1980, Trend Analysis program of the American Council of Life Insurance, in which they provide three health care reports from 2030 A.D.:

> The future is not beyond our control; what we do today will affect that future; we are not at the mercy of totally unpredictable or preordained decisions. The greatest unknown in the future of health care is the *rate* at which alternative futures will take shape. Today's decisions help shape the future. Each day our task is to explore the implications of the decisions which are to be made.

It is my hope that this exploration today will be one productive effort to continue, with you, the joint venture of shaping a positive, productive profile of nursing in the 1980s and for the future. You as educators in graduate nursing education hold a vital key. You must shape it to unlock the door of tomorrow.

GENERIC GRADUATE PROGRAMS IN NURSING

Sylvia E. Hart

The nursing profession is currently embroiled in a series of debates. Debate topics include entry into professional practice, the future of licensed practical nursing programs and diploma schools of nursing, career mobility, titling, accessibility of baccalaureate education for registered nurses from associate degree and diploma schools, and the need for a credentialing center, to name just a few. Having actively participated in several of these debates, it is indeed a pleasure to discuss a subject about which there has been no debate, namely, the need for nurses prepared at the graduate level. As the number of academically-based nursing educational programs continues to grow, as the complexity of nursing services continues to increase, and as the number of citizens needing high quality, comprehensive nursing care escalates, it is obvious that more nurses with graduate preparation are needed so that the quality of nursing education and of nursing practice can be assured.

In 1978, the Commission on Nursing Education of the American Nurses' Association (ANA) stated, "The commission continues to be concerned that demands for nursing leaders, scholars, theoreticians, and advanced nurse clinicians today far outstrip the supply." And in an article written by Cheryl Fields in the November 10, 1980, *Chronicle of Higher Education*, Maxine Loomis, professor of nursing at the University of Michigan, was quoted as saying that 80 percent of the registered nurses currently practicing do not hold even a baccalaureate degree.

O'Koren, in a paper presented in 1978, cites the significant achievements of the nursing profession when she indicates that between 1964 and 1978 the number of nurses with master's degrees increased by 70 percent and the number of nurses with doctorates increased by over 100 percent. At face value these statistics are reassuring, but when we review the National League for Nursing (NLN) data source book we learn very quickly that a significant number of nurses teaching in baccalaureate programs do not hold a master's degree, and that even though there was a 100 percent increase in the number of doctorally-prepared nurses, there are still only about 2,000 nurses in the United States who hold doctoral degrees.

All of these data clearly justify the need for increasing the number of nurses prepared at the master's level and at the doctoral level. We need more master's prepared nurses to assume leadership roles in all segments of the health care delivery system, and we need more master's prepared nurses to enlarge the pool of qualified potential doctoral students. But do these data justify the development of a master's program that admits students without any previous preparation in nursing? I believe they do, especially if several assumptions that I am about to present are valid.

The first assumption is that persons who seek graduate degrees in any field do so because they have clear career goals and aspirations. People go to graduate school to better prepare themselves for a career. While there are no hard data available on the number of persons with graduate degrees who are unemployed, from my own personal observation and experience it seems obvious that most persons with graduate preparation who are unemployed hold graduate degrees in fields where the supply of people with these credentials far exceeds the demand. It is not, in other words, that these people do not wish to work in their chosen field. It is, rather, that jobs are not available for them. We know, too, that the vast majority of nurses who earn graduate degrees remain in the work force and that the job market is wide open as documented by the multiple enticing advertisements we see in nursing and other professional journals. Clearly, once the commitment is made to pursue a graduate degree, there is a simultaneous commitment to remain active in the field.

The second assumption I would like to present is that persons who pursue graduate degrees in any field are, with rare exceptions, adult learners with all of the characteristics that this group possesses. Specifically, they are serious, career-oriented students. They have already demonstrated their ability to be academically successful as evidenced by the fact that they hold at least a baccalaureate degree. Their ability, combined with their goal orientation, makes these students able to assimilate new material more quickly and with more ease than their baccalaureate counterparts who, as a group, are less experienced, less mature, and less clear about their ultimate career aspirations.

The third assumption I would like to present is an economic one specific to nursing. It is no more expensive to prepare a nurse at the master's level than it is to prepare a nurse at the baccalaureate level. Specifically, the faculty-student ratio, which is, of course, the variable that makes nursing education at any level so expensive, is approximately the same for master's level students as it is for baccalaureate nursing students.

I believe that these three assumptions can be accepted without debate. It follows logically from these assumptions that admitting non-nurses into a master's nursing program is not only educationally and economically sound but that this approach addresses two major problems that the nursing profession faces

today, namely the high attrition rate among registered nurses who do not remain active in practice and the small number of nurses, percentage-wise, who hold baccalaureate and master's nursing degrees. In other words, if we want to be sure that nurses remain in the work force this can be accomplished by preparing them at the master's level. And, if we need more nurses prepared at the master's level, we need to attract a larger pool than that currently available from our B.S.N. programs since many of these nurses do not remain in the work force. And, of course, many who do remain in the work force have neither the desire nor the ability to pursue a graduate degree.

One of the questions that must be addressed when a generic master's program is envisioned is, "What constitutes the first professional degree?" At our university — the University of Tennessee-Knoxville — our college offers a baccalaureate nursing program. Graduates of that program earn the Bachelor of Science in Nursing degree. They, of course, are eligible for licensure and we view them as persons who have earned their first professional degree in nursing. Non-nurses who earn our Master of Science in Nursing degree are also eligible for the same license. They also are viewed as having earned their first professional degree in nursing. Does it follow, then, that both groups, namely the baccalaureate graduates and the master's graduates, since both have earned their first professional degree in nursing, exit with comparable levels of knowledge and comparable clinical competence? The answer to that question is an emphatic "no." The basis for the negative answer lies in society's common understanding of what a baccalaureate degree and what a master's degree mean. There is little or no controversy about the distinction that is made. For example, a person who holds a master's degree in sociology is expected to know more about sociology than a person who holds a baccalaureate in sociology. That same expectation occurs when the respective degrees are in chemistry, psychology, zoology, theology, or history.

But what about the person who has a baccalaureate in general studies or in psychology or in anthropology who then pursues a master's degree in sociology? Because that individual's master's degree in sociology is his or her first degree in sociology, does it follow that the knowledge level of this person in sociology will be equivalent to that of a person who holds only a baccalaureate degree in that discipline? I think the answer is obvious. Society, faculty groups, and universities have expectations about what a master's degree means in any field, and I think society has a right to expect that a master's degree in nursing, however it is achieved, represents a level of knowledge and clinical expertise that is clearly more than, and different from, that expected of a baccalaureate graduate in nursing. The challenge facing those who choose to develop a program of this kind is to make certain that this expectation is honored. We believe it has been honored in our program. Let me explain why I believe this is the case.

We admit three groups of students to our Master of Science in Nursing degree program. Students in the first group are nurses who hold baccalaureate nursing degrees. Students in the second group are registered nurses who hold baccalaureates in fields other than in nursing. Students in the third group are non-nurses who hold baccalaureates in other fields. All three groups of students have curricula and course requirements that are specifically designed for them. The greatest differences, obviously, occur during the beginning of each student's program. Non-nurses must master the equivalent of a baccalaureate nursing major both theoretically and clinically. Registered nurses must demonstrate that same kind of mastery of a baccalaureate nursing major. Because there are obvious differences between the registered nurses and the non-nurses, registered nurses have opportunities to demonstrate acquisition of theoretical knowledge and clinical competence through a series of challenge and proficiency examinations and other validation procedures. Assuming for the moment that all three groups of students are full-time, it is obvious that the non-nurse group will require the longest period of time to achieve program objectives for the M.S.N. degree. Registered nurses with degrees in other fields will require less time than non-nurses, but more time than baccalaureate nurses, to meet these same program requirements. B.S.N. graduates, especially more recent graduates, should be able to achieve program objectives in the shortest period of time. But the major point is not the length of time that it takes to achieve program objectives; rather it is that all three groups, no matter how long it takes, achieve the same program objectives. This comparable achievement is assured by the fact that the same graduate-level core courses, clinical concentration courses, and role preparation courses must be successfully completed by all three groups of students. In fact, all three kinds of students are in these courses at the same time. All students must also pass the same comprehensive examination as they near completion of the program. In other words, it is assumed that by the time any master's student is enrolled in graduate-level nursing courses, she or he has acquired the necessary prerequisite knowledge and skill not only to be successful in completing the courses but also to be effective and comfortable in interactions with students with other backgrounds.

To avoid the possibility of compromising on master's level knowledge and clinical competence requirements for persons who were not nurses or who did not hold a baccalaureate nursing degree, we established an M.S.N. program that incorporated characteristics of graduate education in nursing, as

promulgated by the National League for Nursing Council of Baccalaureate and Higher Degree Programs, that was in compliance with the statement on graduate education in nursing published by the American Nurses' Association Commission on Nursing Education, and that reflected the philosophy of graduate education leading to a master's degree as adopted by the U.S. Council of Graduate Schools. And, we designed the program as if we were only going to admit nurses who held the baccalaureate nursing degree. It was not until that kind of program design was in place that we began to identify the additional kinds of learning experiences that other kinds of students needed so that they could ultimately become integrated into the mainstream of the M.S.N. program.

Let me share with you the philosophical premises upon which our Master of Science in Nursing degree program is based. We believe, first of all, that the baccalaureate degree in nursing, or its equivalent, is the only appropriate foundation for graduate education in nursing. We further believe that master's degree programs in nursing should provide opportunities for students to acquire additional advanced knowledge and clinical expertise in a selected area of nursing practice. We believe that clinical preparation at the master's level should focus on promotion, maintenance, and restoration of health with options for specialization available to students. We believe that role preparation within the context of a master's program is essential and that graduates should be prepared to assume roles as teachers, managers, or clinical specialists. We also believe that it is essential that all master's graduates possess beginning research competence and that they are well-schooled in all aspects of the research process.

We believe that graduates of master's programs in nursing should be well grounded in nursing, change, conflict, and leadership theories with the ability to apply these theories to whatever collaborative roles they assume in the health care delivery system. We believe that graduates of the program should be aware of pertinent health and nursing issues and should be able to exert a positive influence on their resolution. And, finally, we believe that a master's degree in nursing is, indeed, an appropriate foundation for post-master's or doctoral education in nursing.

From that philosophy we developed program objectives. I will not outline them for you now, but I am confident that you would find them compatible with program objectives for most master's nursing programs across the United States. I believe, too, that you would find them compatible with NLN accreditation criteria, with NLN characteristics for graduate education in nursing, and with the ANA statement on graduate education in nursing. Based on this philosophy and these program objectives, we proceeded to develop a curriculum consisting of four components: core courses required of all students in the program, regardless of clinical concentration; clinical specialization courses specific to the student's area of clinical specialty interest; role preparation courses specific to the role students expect to assume upon completion of the program; and electives. The core requirement for all M.S.N. students includes courses in applied and pathophysiology, nursing theory, current health issues, behavioral dynamics, statistics, and research, all taken at the beginning of the program, and an advanced seminar taken near the end of the program which focuses on leadership, conflict, change, and political theories as applied to the nursing role.

There are 60 quarter hours of credit required for the M.S.N. degree program. Obviously, for students who are not nurses or who are RNs with degrees from other fields, additional coursework must be completed, which increases the number of credit hours taken to complete degree requirements. The 60 quarter hours are broken down into 24 hours for core courses, 20 hours for clinical concentration courses, 11 hours for role preparation courses, and 5 hours for electives.

After the 60-credit-hour program had been developed and a group of B.S.N. students was nearing completion of the program, we began to identify existing courses from our baccalaureate nursing program that would be appropriate for one or both of the other two groups of students. We then identified essential baccalaureate-level nursing content and clinical experiences from our baccalaureate program and organized this material into consolidated versions of several of our undergraduate nursing courses, usually reducing by about one-third the credit hours allocated to each of these new courses.

The only undergraduate prerequisites for those without the B.S.N. degree are a year of either biology or chemistry and a year of sociology or psychology. We decided that, rather than requiring non-nurses and registered nurses with degrees in other fields to take a large number of non-nursing undergraduate prerequisite courses, we would identify essential concepts from the natural and behavioral sciences and incorporate them into modular, largely self-paced courses which could be taught and monitored by our nursing faculty. One of these courses is entitled Integrated Biomedical and Health Sciences. It was designed to insure that all students begin the clinical component of their program with comparable background in the natural sciences. The course includes essential concepts from physiology, microbiology, genetics, physics, and nutrition. Another course, entitled Developmental and Psychosocial Theories, was designed to insure that all students have comparable background in the behavioral sciences prior to beginning the clinical nursing component. Students who believe they have already acquired the content from these two courses

may present evidence and request a waiver of the requirement, or they may challenge the course. Non-nurse students begin the clinical courses that provide the equivalent of a baccalaureate nursing major by taking two courses called Basic Concepts of Professional Nursing. This 8-credit-hour sequence is comparable in many ways to our sophomore and junior level nursing process courses. The major difference is that within this 8-credit format students acquire the same knowledge and clinical expertise as our undergraduate students acquire in a 12-credit sequence. Having acquired the basic knowledge and skills related to the nursing process, students move into three undergraduate clinical courses, each carrying five credits. The first is Nursing the Child-Bearing Family, the second is Psychosocial Nursing, and the third is Acute Care Nursing. We have 10-credit courses in these areas in our undergraduate program. Following the completion of these three courses, students take a 6-credit course entitled Clinical Nursing Practicum and Seminar. During this course, in which they spend 24 hours per week in actual clinical practice, students continue to refine and expand their clinical practice skills and gain knowledge and expertise that make them more confident as well as more competent. They are also required to take undergraduate courses in comprehensive health assessment, nursing research, pharmacology, and community health nursing. These four courses are also required of our B.S.N. students.

The courses that I have just described take approximately four quarters of full-time study to complete. Upon completion of these courses students have acquired within a four-quarter framework the same knowledge and clinical skill that our baccalaureate students have acquired within a six-quarter framework. Faculty who have observed both groups of students agree unanimously that the graduate students are comparable and in many cases superior to our baccalaureate students in the kind of clinical nursing that they are able to practice upon completion of this sequence.

Registered nurses are not required to take Basic Concepts of Professional Nursing. Instead they take a course entitled Transition to Professional Nursing which is also required of registered nurses in our baccalaureate program. Once they have completed this course they are eligible to either take or challenge the three 5-credit clinical courses. The clinical practicum course is not required for registered nurses. They must, however, complete our undergraduate assessment and research courses as well as our course in community health nursing. The students then move into the graduate-level core courses that are prerequisite to most of the graduate-level nursing courses, namely pathophysiology, statistics, research, nursing theories, behavioral dynamics, and current health issues. They take these courses with other master's students, including those with B.S.N. degrees, and they meet the same course requirements as all other students do. From this point on they move with all other students in the program into their area of clinical specialization. While we require that all students admitted to the master's program declare an area of clinical specialization when they are admitted to the program, it is the generic students who tend to change their minds after they have moved through the baccalaureate nursing major equivalent courses. The vast majority of the non-nurses indicate upon admission that they wish to pursue clinical concentration in family-centered primary care nursing. However, once they have experienced other kinds of nursing, they tend to distribute in about the same manner as our B.S.N.-prepared graduate students do. Currently, we offer three clinical concentration options; one in family-centered primary care nursing which prepares family nurse clinicians, one in secondary-tertiary care nursing which prepares nurses for advanced clinical practice in acute care settings, and one in community mental health nursing. Our role preparation tracks are for either teacher preparation or preparation for advanced clinical practice, and students tend to be about equally divided between these two options.

In September 1979, we admitted our first group of non-nurses to the master's program. Twelve students with degrees from a variety of disciplines began their coursework at that time. Currently, there are 10 remaining in this group, the other two having discontinued, one for personal reasons and one because of relocation. This group is expected to complete all degree requirements in December 1981, and will be eligible to write the state board licensing examination in February 1982. Another group of 15 non-nurses was admitted to the program in September 1980. For non-nurses the length of the program is approximately nine quarters of full-time study. There are 23 registered nurses enrolled in the program, and approximately 40 nurses with B.S.N. degrees.

Because we have not yet graduated any non-nurses from the program, there are obviously some unanswered questions. The first question and the one asked most often has to do with the amount of time that it will take these graduates to be productive members of the health care delivery system. That, of course, is the same question continually asked about baccalaureate nursing graduates and, for that matter, graduates from all types of nursing programs. While we certainly cannot say that a non-nurse who graduates from the M.S.N. program will, at that moment, be as clinically comfortable and confident as a person who entered the program with a B.S.N. degree and who had two or three years' work experience after graduating from the baccalaureate program, we have every reason to believe that within a relatively short period of time, perhaps six months to a year, this person will be making a very significant contribution to nursing. The rate at which any graduate achieves this level of performance is as individual as the students who graduate from the program. It is impossible to make this prediction with

any more precision, but we do know for a fact that within the 9-quarter framework the non-nurse student who receives the M.S.N. degree will have had over 1700 hours of clinical practice experience — 920 in baccalaureate-level courses and 800 in graduate-level courses. Students who choose clinical practice as their role receive an additional 30 hours of clinical practice experience.

We are encouraging our non-nurse master's students to get into the mainstream of the work force upon graduation, before they begin to seek employment as teachers of nursing or as clinical specialists. For B.S.N. graduates and for registered nurses we require at least one full year of nursing experience prior to admission to the program. We do this so that they will enter the master's program with a clear notion of their career goals and aspirations. Obviously we cannot make a requirement for non-nurse students, since they cannot practice nursing until they are licensed. We make this recommendation knowing that we cannot enforce it, since no college or university can control the behavior of its graduates.

There is one other question I have not yet addressed. It is a question that emerges from several widely accepted facts. We know that persons with graduate degrees remain in the work force. We know that leadership for the profession has and will continue to come primarily from persons with graduate preparation and, even more specifically, with doctoral preparation. We know that nurses with doctoral preparation in nursing are in extremely short supply. Why, then, knowing all of these things, did we decide to develop a generic master's program rather than a generic doctoral program? We made the decision to go the master's route for several reasons. First, we believe with conviction that any doctoral program in nursing must be a legitimate, respected, understandable doctoral-level program so that those who hold that degree are accepted into the community of scholars that embraces doctorally prepared persons from all disciplines. I am not now addessing the question of the academic degree versus the so-called professional degree. That decision, after all, must be based in large measure on the type of university that houses the doctoral program. My point is that, wherever the doctoral program in nursing is housed, the program must meet the same rigorous standards set forth for all doctoral programs on that campus. Our college is not yet ready to meet those standards and, until we are, we will not seriously entertain the possibility of developing a doctoral program.

The second reason for deciding to develop a program at the master's rather than the doctoral level has to do with the characteristics of our potential pool of students. Based on the number of students with baccalaureates who had been applying to our B.S.N. program, we knew that this group would be better served by a generic master's program than by a B.S.N. program. We were also aware of large numbers of registered nurses who, for a variety of reasons, had earned baccalaureates in other fields. Since these students would have to make a two-year, full-time commitment in order to earn a B.S.N. degree, we realized that with approximately that same time and money commitment they could earn very legitimate M.S.N. degrees. It is doubtful that significant numbers of students, especially non-nurses, would be in a position to make a commitment to a doctoral program that, for them, would take about five years to complete.

The third reason for deciding to develop the generic track at the master's level has to do with society's and the profession's readiness for and expectations of nurses with graduate degrees. Health care agencies are beginning to show considerable interest in hiring and utilizing appropriately nurses with master's degrees in nursing. Nursing education, of course, has always had a strong interest in and need for nurses with master's degrees in nursing. Nursing deans and department heads across the country have similar expectations about what they can expect an M.S.N.-prepared nursing faculty member to do. Nursing service administrators are developing similar expectations about what an M.S.N.-prepared nurse can do in a service setting. I believe that a nurse with the M.S.N. degree as his or her first professional degree in nursing, who has had a year or two of practice experience, can meet those expectations as defined by nursing service and nursing education. But I doubt that a nurse with a doctoral degree as his or her first professional degree and with a year or two of experience can meet the expectations people usually have for persons with doctoral preparation. Perhaps that is because the vast majority of nurses who currently hold earned doctorates have had a variety of professional experiences interspersed between their bachelor's, master's, and doctoral degree programs. Consequently, for the time being, at least, I think it would be disastrous to, once again, confuse society and our profession with a variety of different meanings attached to the academic degrees nurses hold.

What are the variables that make the establishment of a program with multiple student tracks a successful venture? First and foremost, there must be a significant cluster of qualified faculty who are bright, energetic, courageous, and, perhaps most important, flexible. Second, a group of bright students must be identified who are willing to make a commitment to a program of this kind, knowing that it will be a very demanding and challenging one. Third, the program must be developed within a supportive and flexible university that is willing to accept alternative approaches to the achievement of educational goals that are compatible with the university's mission. Fourth, there must be appropriate clinical resources

available. And finally, of course, there must be financial support that will permit assignment of sufficient faculty and support staff to the program, who will have the time to develop new courses and new curricular options and who can provide appropriate guidance and support to students. We were very fortunate in having Kellogg Foundation support for the establishment of the generic track of our master's program, and without that support this program would not now be a reality.

I started out by stating that there is no debate about the need for more nurses prepared at the graduate level. Nursing needs leadership, perhaps more desperately now than it has ever needed it before. In my view, the biggest single problem facing nursing today is our collective lack of adequate educational preparation. I find the statistics I quoted earlier — the fact that 80 percent of our registered nurses still do not hold a baccalaureate degree — to be embarrassing indeed. This statistic was quoted in the article in the *Chronicle of Higher Education* entitled "Despite Problems, Research Increases at Nursing Schools." In this article, Dr. Barbara Hansen from the University of Michigan cites the difficulties that nurse researchers have in obtaining funds for their research proposals. She indicates that quite often when nurses submit research proposals to federal funding agencies, the review panels question the academic qualifications of the nurse and compare these qualifications to those of researchers from other disciplines who have submitted proposals for funding. The fact that nurses cannot compete on equal footing with other persons for scarce research dollars is a clear indication of the fact that nursing has a long way to go before it will be respected as an academic and professional discipline. Before we can assume significant leadership roles in the broad arena of health care, we need many more nursing leaders who can move the profession to a position where the reason for our existence can never be questioned and where our contributions to health care are measurable, significant, and highly visible. It is only then that nursing can call itself a leadership group within the health professional fields. And that can only happen when significant numbers hold graduate degrees.

Leaders, after all, lead on the basis of what they know. Leadership styles have been studied extensively over the past several decades and we know that people are effective leaders for a variety of reasons. There is one thing that all effective leaders have in common, however, and that is the knowledge base from which they operate. An economist cannot provide leadership in the development of sound economic policies unless he or she has a sound, broad, and deep knowledge base about economics. A lawyer cannot provide leadership in the development of legal policies and procedures unless he or she is extremely knowledgeable about laws, their interpretation, and their application. A college president cannot provide leadership, no matter how charismatic or affable he or she might be, if this individual does not have a sound and comprehensive knowledge about higher education with all of its implications. By the same token, nurses cannot provide leadership unless they have a sound and comprehensive knowledge about nursing and about health care and about the relationship of nursing to the health care delivery system. It is only by preparing knowledgeable nurses in large numbers at the graduate level that we will ever be able to assume the position of respect and legitimate importance that we have sought for so many decades. By enlarging our horizons and attracting persons into our graduate nursing programs who are bright, mature, career-oriented, and committed to making a contribution to nursing and to health care, we can solve the problems that the profession is now facing. This program is one attempt to increase the number of nursing leaders to whom we must look in future years to bring about the improvements that the profession and society so desperately need.

DEBATES ON ISSUES IN INNOVATIONS

I. Satellite Programs and Flexible Scheduling: Can Quality and Integrity Be Maintained?

Position 1: The Case for Outreach Programs

Helen Kohler

Rather than starting with the assumption that quality of an educational program declines with the distance from the main campus, I will start with the fact that program content and outcomes can be identical on and off campus. A great deal of effort goes into assuring this. In the time allotted today, I want to discuss briefly five items which need careful attention. These are:

1. The isolated learner phenomenon;
2. Library and other educational resources;
3. Evaluation strategies;
4. Nurturance of host community-university relationships;
5. Holding the bag.

(Tough canvas is needed for managing strange animals. Everyone who has hunted side-hill fimps — those little animals with shorter legs on one side because of going round and round the mountain — knows something about this.)

1. Isolated Learner Phenomenon

There is a tricky balance involved here for community-bound, rural nursing leaders. Some contact with the main campus is needed for enculturation into the institution at which the degree is earned. Part of this involves contact with the larger peer group on the main campus. At the University of Maryland, there are approximately 400 graduate students in Baltimore as compared to, at most, 30 in the off-campus sections. It is sometimes possible to have a slightly larger peer group in geographical areas where a large distance is covered and nurses work in varied programs and do not know each other, such as on the eastern shore of Maryland. One other buffer against isolation occurs where Area Health Education Centers (AHECs) are in existence. These centers offer interdisciplinary experiences with other students from the main campus. We have this set-up with the Cumberland AHEC in western Maryland.

Having Outreach Program faculty come from the main campus also helps in preventing isolationist learning. These people bring new ideas and facilitate the use of creativity through truly relevant mind-stretching and needed role-modeling of high-level nursing performance in the home area where most of the students will continue to practice. Well-prepared and willing faculty are needed in the off-campus endeavors. (We encountered our first instance of "unwillingness" this semester, and it was really very difficult to manage.)

2. Library and Other Educational Resources

A great deal of time, effort, and money is allotted to this item. Many books need to be bought. (We spent $600 for only the most necessary references for this fall semester.) Much time and effort are spent by the Outreach Program secretary in copying references for courses. At the moment, a $50 Xerox bill is being run up at the main campus library for just one spring semester course. The Outreach secretary can also get library books for students when they are on campus, or send them to students in response to calls. Traveling faculty provide bookmobile services as well.

For the best learning to take place in statistics courses, portable computer terminals are needed. We are managing this only on the second round of the research and statistics course, and are fortunate to be able to hook up with phone service at the AHEC in western Maryland. (Portable research professors are a scarce item, also.)

Our master's contract did allow for purchase of two portable, programmable mini-computers for use in the research courses and for thesis data.

3. Evaluation Strategies

Rather than looking at the campus and its resources in evaluating satellite programs, it is necessary to look at what is happening with students — what they bring in and take out — in terms of enhanced performance and a theoretical basis for it. Health agencies and institutions in the rural areas appreciate the new ideas brought by staff members who are also graduate learners. A number of directors of nursing service have noted that many personnel in their institutions are able to grow and learn as spin-off from contact with graduate students.

Ongoing student evaluation of the program is very useful. Part of this involves checking very negative evaluations with the most able students in order to put them in proper context. For instance, when I receive bitter complaints about the statistics course, I will casually discuss the course and learnings from it with three or four of the top students in the class to determine whether there are problems I really do need to attend to.

Another important evaluation strategy is the comparison of the Outreach students with the larger peer group to see whether they are a distinct subgroup, or whether the inability to attend class on the main campus is the only difference. It has been our experience so far that in some courses the off-campus sections perform at a higher level than main campus sections. I became aware of this last year when teaching Epidemiology off campus, and checked to see whether a colleague teaching one of the nursing courses was finding the same distinction. There were clearly more As on exams and better prepared discussions in the off-campus sections of our courses.

4. Nurturance of Host Community-University Relationships

It is necessary to survey periodically the users of the Outreach Program products — for example, directors of nursing service, community college nursing department heads. Local advisory meetings, at least on a yearly basis, and informal contacts with key people in between, seem to be the best ways to accomplish this kind of survey. Through such contacts I have learned of the appreciation of new ways of thinking brought by the graduate students. The regular contacts with key personnel are also necessary in order to have an idea of overt and covert leaders who will be supportive of the Outreach endeavors.

Part of the above presumes having a reliable grapevine, which must be nurtured carefully and fed well. Along with this, some sort of rumor clearinghouse would also be a big help. Incredible stories are spread and need to be caught early.

5. Bagholder

(If you haven't hunted side-hill fimps, maybe you know about elfadridges, which are very similar.)

I don't believe that it is necessary to have somebody designated as director of the Outreach programs. The various tasks may be spread among a variety of people, but somebody must serve as a student advocate, as a support to faculty roadrunners, and as a program facilitator in general. It is also necessary for someone to have the "bigger picture" in mind and do things like develop 10-year plans with the realization that, generally, the off-campus endeavors really are a very small operation of the total school.

There are a number of other considerations that could be discussed, many of them in the category of "plot and scheme." Our attitude has gotten to be "how can we do it," with little consideration of whether or not it is possible. Finally, the bottom line is that quite a bit of what goes on in the off-campus class sections is *at least* as good as what is offered on the main campus.

Position 2: The Case Against Outreach Programs

Betty R. Rudnick

The graduate programs which have made the greatest strides and have the national reputations are those which have their nursing schools on the university campuses. This is not to say that schools with satellite campuses are not fine graduate programs, nor that all one-campus nursing schools are great. There are uncontrolled variables in every instance, but the empirical evidence as represented by scholarly production speaks for itself. I truly believe that, at this time, there is no finer nursing program than the Texas Woman's University (TWU) College of Nursing, and this is both the master's and the doctoral programs; my contention is, however, that making the programs fine and keeping them fine, as well as keeping the several campuses' programs completely the same as one another, requires a great deal more concerted effort than would be true on a single campus, and the energy and effort used for this purpose might make a signal contribution elsewhere.

Represented prominently at this meeting is the graduate program of the University of Alabama School of Nursing in Birmingham. That is a fine school, which gains increasing reputation nationally each year. The strides made by that school have been faster since the campus has been unified in Birmingham than when the University was in Tuscaloosa and the clinical campus was in Birmingham. True, many other changes than this unification have occurred, but I consider this to have been a major substantive change.

Communication is the major element on which time and effort must be spent in any case; when you are dealing with satellite campuses, communication can never be taken for granted. A clear and thorough plan must be created and followed carefully, and even then there are many areas of difficulty presented daily. Some of the communications methods which have been used at the Texas Woman's University College of Nursing, including special hardware and transportation, are:

The Qwip — This is a machine, leased and serviced at a relatively high expense, which must be maintained on each campus. Printed material can be inserted at one Qwip and transmitted via telephone to another machine at a distant place. The received copy is somewhat distorted, and special telephonic arrangements must be made between clerical persons, but Qwip provides nearly instantaneous printed communication.

Computer Terminal — When each campus has a computer terminal and telephone connection exists with the master computer, as is true for TWU College of Nursing, an individual on one campus can send printed communications to a colleague on another campus. The computer terminals have now replaced the Qwip for us. The hardware for the computer terminals represents a larger outlay of money than the initial money required to acquire the Qwip, but the long-term expenditure is very much less, and no one is subjected to the smell of burning chemicals, which is a perquisite of the Qwip.

Telephone — We maintain a Tex-An line — known to the world outside of Texas as a Wide-Area Telephone Service (WATS line) — by which, for a flat fee, an unlimited number of in-state telephone calls may be made each month. Through the use of this service, the faculty of the several campuses may converse as necessary, and the administrators on the satellite campuses may be in telephone contact with the dean in Denton, without stinting.

Airplane — An airline which flies primarily in-state makes half-hourly and hourly flights between an in-city airport in Dallas and an in-city airport in Houston. The budget of the College is planned to include essential intercampus travel for committee meetings and administrative work.

Automobile — A large sum of money goes into the reimbursement of faculty for intercampus travel; it is a state requirement that any persons required to travel more than five miles from the home campus must receive 18 cents per mile in reimbursement, along with food and lodging when appropriate. At this time, out-of-state reimbursement is considerably below actual cost of food and lodging.

The above methods are the hardware of communications between the main campus and the satellite campuses; the software of such communications are the minds and hearts of the faculty. Tremendous reliance must be placed on the *desire* of the faculties of the several campuses to coordinate the offerings of the campuses so that the program for the master's or the doctoral program is the same, regardless of the geographic location of the student.

Under the heading *Organization and Administration*, the National League for Nursing (NLN) sets forth the following statement of criterion: "The philosophy and purposes of the school of nursing are consistent with the philosophy and/or purposes of the parent institution." We can add a paraphrase of that statement: The philosophy and purposes of the main campus of the College. My observation is that the consistency is in direct ratio to the geographic distance between campuses. The disaffection with the activities of the parent school, the feeling of being an unloved or least-loved child, multiplies factorially as the distance lengthens, and to prevent this from becoming pathological, the dean must constantly mend fences and take care not to damage them.

Still under the same heading in the statements of criterion for accreditation, we find statements referring to the relationships with, among, between administrative authorities, support units, and the College of Nursing. To be able to answer affirmatively to such queries, and to show evidence, requires attention to appointment of representatives to committees from each campus, communication between such representatives and the several campuses, representatives on central committees and councils of the University, and attention to acquisition of travel funds which make it possible for the representatives to attend their meetings. Then, means for communication of decisions and plans which emanate from meetings must be made, and a custodian appointed to see that the communications are effected.

Policies, rules of procedure in written form, and reviews of same can be enacted, but are they followed? Again, administrative effort must be specifically directed to follow-ups of such arrangements, or they tend to break down over time. With the best intent in the world, policies, rules of procedure, and plans little-by-little can be bent, broadened, narrowed, subtly changed, or eliminated and replaced by quite different activities.

The NLN criterion asks whether the school of nursing has an administrator prepared in a certain way. The school with satellite campuses has not one, but several administrators; the number depends on the number of campuses.

Time does not permit the speaker to cover every area of the self-study report which a program makes to the League, but I find this a very helpful way to demonstrate to oneself the problems which satellite campuses represent. All of the above comments are pertinent, but if you will take the hardware representations which I spoke about, and consider the effort required to build each of these into your program, it becomes very clear what great amounts of time, effort, and money could be put into a single-campus

school if these were not being used for a multi-campused school. Yes, a school can maintain quality and integrity with satellite programs and flexible scheduling, but oh, it is *so* much harder!

The Supreme Court has found in questions of racial discrimination that separate is inherently unequal; this doesn't even have to mean that it is worse — it is simply different. Great specific effort must be made to see to it that when they study on different campuses, all students are treated the same. My school in particular makes this effort and achieves the purpose. A one-campus program doesn't have to make anything like the same effort.

Finally, I see the difference between single campus programs and multi-campus programs to be similar to the crocheting of an afghan — there are many patterns which one may follow; the cover may be crocheted in one large block; lots of small diamond-shaped pieces may be made and connected together; and so on, and so on, and so on. Each afghan may be beautiful, and each may keep the owner warm for a nap on the couch, but they are different, and some are much simpler to crochet than others.

DEBATES ON ISSUES IN INNOVATIONS

II. Progression to the Nursing Doctorate: How Can It Best Be Achieved?

Position 1: The Master's Degree as Prerequisite

Elizabeth Lenz

The rapid emergence of doctoral programs over the past decade has given rise to a number of issues about the desired nature and direction of doctoral nursing education. One such issue concerns optimal means of progressing toward the doctorate. The central question which Dr. Waltz and I will address is whether a master's degree in nursing ought to be a prerequisite for entry into a doctoral nursing program. The two positions which we will take are as follows: the first position is that progression toward the nursing doctorate can best be achieved by first earning a master's degree in nursing; the alternative is that progression toward the nursing doctorate can best be achieved by entering a doctoral nursing program *without* having to first earn a master's degree in nursing, i.e. entry following baccalaureate preparation in nursing. The first position on the issue reflects the modal pattern in nursing; the second reflects an innovative pattern which is currently available in (at least theoretically) two nursing doctoral programs, and is the pattern commonly followed in some scientific disciplines.

By defining the issue in terms of these two positions, we are admittedly deemphasizing for the purposes of the debate some related questions, such as whether nurses with baccalaureate or master's degrees in other disciplines should be admitted to doctoral nursing programs, as well as specific questions related to the nature of prerequisite master's level preparation.

The position which I will be taking on this issue is that progression toward the nursing doctorate is, and will continue to be, best achieved by the student's *first* earning a master's degree in nursing. Central to my argument is the idea that the master's is and *will remain* a viable degree for individuals who ultimately progress to the terminal doctorate. I will attempt to establish its viability from the perspective of the profession as well as from the perspective of the individual.

In relation to the profession, master's-prepared nurses are essential to fill a wide variety of positions. For the purposes of this discussion I will not focus on the nurses who choose to terminate their education at the master's level, but will simply acknowledge the vital role which they have played and will continue to play. My focus is on master's program graduates who intend to pursue doctoral study. Although these individuals may be in the work force for only a brief period between master's and doctoral study, they constitute an important source of well-prepared manpower for positions which often are vital to determining the nature of nursing practice. Given existing shortages of nurses prepared to fill positions for which the master's degree is appropriate, the profession cannot afford the loss which would result from shortcircuiting master's level preparation, even for the relatively small (but growing) percentage of potential master's graduates who ultimately desire doctoral degrees.

The master's graduates who go on to doctoral study are frequently the brightest and the most creative of our products — in short, the cream of the crop. Even though their employment in the work force may be brief, they make valuable contributions as a result of knowledge and expertise gained at the master's level. To cite a brief example, virtually all master's programs in nursing provide instruction in research methods and many require a thesis or field study. These experiences provide the basis for the master's graduate who is aspiring to doctoral study to identify salient, researchable questions which arise from practice; to be a knowledgeable, active and valuable participant in clinical research being directed by others; even to develop, direct, and publish small-scale research projects within his/her area of specialization. The profession should not be deprived of those contributions.

A final point to be made from the perspective of the profession is that the learning experiences gained during master's level of study and in post-master's work experience provide essential underpinnings for making contributions which are more relevant to the real world during and following doctoral study. We all are aware of the problems of arm-chair theorizing and research. Clinical, administrative, and educational theory and research in nursing will be more likely to address the most important questions, take into account the most salient dimensions, and be most useful if the investigator has attained thorough understanding of the phenomena involved. The depth of clinical knowledge provided in master's study, coupled with post-master's experiences in practice settings, help to provide such understanding. A very real danger in short-circuiting master's preparation is that our knowledge advancement will occur in relative isolation from the reality of nursing practice.

Cleland has addressed the value of the master's degree to the individual by stating that the master's in nursing opens the door to many opportunities for professional contributions. From her perspective, the

master's degree has potential for increasing the recipient's income level and is useful for those who begin but do not complete the doctorate for one reason or another. I would add that, for some positions which require a doctorate, a master's degree may also be required, because it is assumed that valuable knowledge was gained through the master's experience. Although the above arguments are important, I would assert that for the individual the requirement that the master's degree precede the doctorate has more than economic value. This is true for a variety of reasons which I will elaborate briefly. First, the master's provides a tangible landmark along the way in a potentially long-term graduate educational pursuit. Not only is the sense of accomplishment important, even though the master's may be perceived as a short-term goal, but also the doctorate can be approached with renewed vitality as a new and exciting undertaking. Frequently, after one or two years of intensive study, the graduate needs a "breather." This is particularly true of the individual with family responsibilities.

Second, we can't ignore the potential import of the post-master's, pre-doctoral work experience to the individual. The master's graduate emerges with an approach to nursing which is different from that with which he/she entered the master's program. The graduate has learned new information which should be digested, tested, and applied in a non-student role. New conceptual and practice approaches developed during master's study often should be tried out and modified before the individual moves on to further academic pursuits.

The post-master's work experience not only helps the individual match his/her ideas to reality and to gain credibility among peers, but also helps develop further insight into what has been learned. The master's degree as a prerequisite thus helps to build in a logical progression of career experiences which help the individual to articulate the educational process with the real world and to better define his/her potential contributions to the discipline.

Third, master's study, if it is prerequisite to doctoral work, helps to serve as a screening device, hopefully assisting those nurses who are the most able and the most highly motivated to select themselves into doctoral programs. Master's preparation is typically different from baccalaureate preparation, in that it is more highly specialized, requires more creative and independent thinking, and requires more involvement with research. Exposure to graduate nursing education at the master's level helps provide a taste of what doctoral study is like. Therefore it is useful in helping the individual student to assess his/her own strengths and weaknesses in relation to further study, as well as to more clearly define career goals. Parenthetically, I would add that the self-selection feature of master's preparation is useful from the viewpoint of the educational system. Because resources are short and demand is high, we can scarcely afford to admit to doctoral programs either those who are unsure of their desire to attain the doctorate or those who are unable to handle the challenge.

Fourth, the master's program is a valuable prerequisite for the individual, because it lays useful groundwork which can, in the long run, expedite the doctoral experience. Master's study generally provides for the student's mastery of a specialized content area within nursing, which can then be amplified and applied in doctoral study. Students who come to doctoral programs with a thorough understanding of their substantive specialty area within nursing, gained through master's study and post-master's work experience, are in an excellent position to make the best possible use of doctoral learning experiences. Frequently they have identified at least broadly the research questions within their specialty area which need to be answered and which they wish to pursue. They have sufficient experience in the clinical setting to be able to evaluate the feasibility of specific research strategies. They have identified the gaps in their knowledge which doctoral study can best help them to fill. In short, they are better able to select a doctoral program which is congruent with their own needs and goals, and to proceed through doctoral study efficiently with a well-defined contextual background in which to place new learning.

Finally, an interesting phenomenon which is occurring today is that master's graduates frequently do not remain within their chosen specialty area following graduation. As they broaden their horizons through exposure to different clinical specialty areas and different settings, they evolve new ways of viewing nursing. Their interests and perspectives often do not fall neatly within our traditional content areas, yet provide a rich amalgam which serves as an appropriate backdrop for the kind of abstract thinking about generic concepts and theories in nursing which frequently is required at the doctoral level. To preclude the opportunity for such diversity and innovative thinking would rob not only the individual but also the profession of new perspectives which frequently shed much needed light on complex problems.

In nursing we sometimes have fallen into educational patterns not by design, but by virtue of our gradual evolution. Some of these patterns we have seen fit to question and revise — being gifted with 20/20 hindsight. My assertion in this debate has been simply that the evolutionary pattern which has established the master's as a necessary prerequisite to doctoral education is not one which we should discard easily. The benefits to the individual and to the profession are too substantial to ignore.

Position II: The Direct Route to the Doctorate

Carolyn Waltz

I shall argue that the post-baccalaureate route toward the doctoral degree is the path of choice when the intent is to prepare nurse researchers and/or when a major aim of the educational experience is to produce nurses who, regardless of their primary role, will remain actively involved in the conduct of nursing research.

The post-baccalaureate path to the doctorate immerses nurses in a research milieu and affords them multiple opportunities to study and work closely with nurse researcher mentors early in their professional careers. Because of this early and ongoing exposure to research and researchers, the probability that students will be socialized into and remain in the researcher role after graduation is increased.

Within the context of the post-baccalaureate doctoral program, learnings traditionally acquired in master's programs are still viewed as important, but attainment of the master's degree per se is not given landmark importance. That is, selected content included in a master's program can be, and usually is, incorporated into the post-baccalaureate doctoral program of study. What is not built into the program is the tendency to stop at the master's level, i.e. to operationalize the master's as a terminal degree. Master's-level learnings incorporated into a post-baccalaureate doctoral program can, in fact, be tailored to the individual student's needs and interests more than is the case in most master's degree programs, hence rendering the content especially meaningful and relevant to the student's career goal, i.e., to become a researcher. Students in a post-baccalaureate doctoral program who are preparing for a career in clinical nursing research certainly need clinical knowledge and skills to serve as a substantive basis for their research, but what they need in most instances is quite different from what is provided in the typical master's program in nursing. More specifically, in most master's programs when the primary objective is to prepare practitioners or clinicians, clinical content and experiences are usually designed to allow students to study a given clinical area in depth and to work on an ongoing basis with a small number of patients in order to assess their progress when different interventions and/or nursing techniques are employed, and/or to expose students to a variety of patients who demonstrate certain problems or conditions that graduates are likely to encounter as clinicians. In light of this, one could argue that if the goal of the doctorate is clinically or professionally oriented, the best path is the master's in nursing and then the D.N.S. or another more professionally oriented doctoral degree.

In the post-baccalaureate doctoral program, however, the concern is more with designing for students clinical experiences that will facilitate their conduct of clinical nursing research rather than their ability to perform in the clinical arena *per se*. Hence clinical experiences are selected to allow students to study a generic concept or clinical variable in a population of patients among whom the concept or variable is expected to differ. For example, a student in a post-baccalaureate program who is interested in conducting research in pulmonary nursing might be afforded the opportunity to study this content in breadth and depth, as well as to work with a variety of patients at different points on the continuum of dyspnea, so the student may expand knowledge and skill in raising appropriate researchable questions, formulating testable hypotheses, and delineating and measuring variables of import in conducting research in pulmonary nursing. In this manner, within the post-baccalaureate program, the logical progression in learning from baccalaureate to master's to doctorate to doctorally prepared researcher is enhanced, resulting in greater articulation between levels of content, thus fulfilling the need (identified by Cleland in 1976) to plan a doctoral program as a total graduate experience.

Cleland, in the same article appearing in *Nursing Outlook* in 1976, recognized the disparity in existing master's programs as the justification for this need.

Today, four years later, there is still a great deal of variance across master's programs in nursing in regard to the time needed to complete the master's and credit hours required, as well as the specific theoretical and clinical content and experiences provided. Thus, the label "master's in nursing" has no universal meaning nor expectations attached to it.

Within the post-baccalaureate doctoral program, master's-level learnings necessary and important for all students are specified, unnecessary learnings are eliminated, and hence degree requirements are streamlined so that all students can advance more economically and efficiently toward the doctoral degree. Similarly, because expectations are well defined, especially capable students can progress more rapidly if they so desire. This is especially important given the dire need for doctorally prepared nurse researchers and teachers, as is well documented in the literature.

Given that the post-baccalaureate doctoral program purports to prepare researchers, not clinicians or specialists in nursing service administration, admits students with work experience after the baccalaureate, and provides clinical learning experiences tailored to the researcher role within the curriculum, the value too frequently attributed to the post-master's work experience becomes a moot point. In fact, since the focus in most master's programs is on clinical and/or functional content and skills rather than research per se, subsequent post-master's work experience in these

roles too often serves either to socialize nurses out of instead of into researcher roles or to prolong the time required to produce a sufficient number of researchers, thus acting as a deterrent to fulfilling the manpower needs of the profession.

In addition, researchers will always need to devote considerable attention to the work setting in conceptualizing and designing nursing research that is clinically based, regardless of whether they have had post-master's work experience.

By advocating the post-baccalaureate doctoral program as the pathway for preparing researchers, I am not ignoring the fact that at the present time most nurses pursuing the doctorate have the master's degree. Provision for such students can easily be made by allowing them to demonstrate, by challenge and other means, their ability to meet early program learnings and to enter the doctoral program at a level appropriate to their own needs. Similarly, I am also cognizant of the fact that, in order to teach in many nursing programs and/or to enter many post-master's doctoral programs, a specific requirement is the master's in nursing. I firmly believe, however, that we must look not at what is but at what ought to be in order to benefit the profession as a whole.

Schlotfeldt, in a 1978 *Nursing Outlook* article on doctoral education in nursing, recognized the need for a remarkable reorientation throughout the nursing community if nursing is to make its appropriate and necessary contributions to the health care system. More specifically she stated:

> . . . Reorientation will require nurses to be committed to creating a new future, in contrast to preserving the status quo; to acting, in contrast to reacting; to being influential, in contrast to being unduly influenced; and to being in control, in contrast to being controlled. Reorienting nursing's approach to preparing professionals may well be the most promising approach to effecting needed changes in the nursing community and, thus, for effecting desirable changes in the health care delivery system (p. 306).

DEBATES ON ISSUES IN INNOVATIONS

III. Should The Product of Graduate Education Be An Advanced Generalist or a Specialist?

Position 1: The Case for a Comprehensivist

Genevieve Bartol

We hear that nurses are uniquely involved in the promotion of health and the prevention of illness. Some are fond of saying physicians are concerned with curing; nurses with caring. I won't argue those points — I'll just agree nursing is evolving, presenting an ever-changing challenge. To the questions, "How should nurses be educated to meet this challenge? Should the product of graduate education be an advanced generalist or a specialist?" I would answer "a comprehensivist."

Educational philosophers have repeatedly stated that the most effective education is a liberal education. True education fosters a student's inherent love for learning and helps him or her acquire the tools for learning. Educators remind us that in our rapidly changing world, where the "half-life" of knowledge is now less than five years, a liberal education is the only sensible response. Preoccupation with imparting facts as though there is a fixed body of knowledge which will prepare one as a specialist is self-defeating. We need to encourage the development of a disciplined mind. We do not call educated a person who has simply mastered a skill or gained proficiency in a narrow aspect of a field. We expect educated persons to have a conceptual scheme which rises above the level of a collection of facts. We realize theories are provisional. Theories simply enable us to organize available knowledge and, more important, guide our search for additional knowledge. The truly educated person learns to reflect on his or her own experience — to organize, integrate and discover new knowledge. The most important characteristic of an educated person is still as Dewey expressed it, a person who possesses the desire to go on learning.

I say that nurses need to be educated in a liberating manner to respond to humanistic concerns humanistically in a world and health care system where technological advances threaten to overshadow our purpose of caring for others. Nursing needs to deepen its general education base. Nursing needs the humanities and social sciences as well as the physical and biological sciences. Nursing needs to avoid a path which is essentially a narrow one of job preparation.

This does not mean that graduate education should not provide some firsthand experience in some practical applied area. Rather, we simply need to avoid an education that prematurely labels its graduates as specialists and experts. We need to direct less attention to a specific subject matter and greater attention to the style and form in which that subject matter can be best nurtured. We will be dependent if we do not receive a general education which enables us to collaborate. We need a commonality of our educational core to promote connections between professions. The generic preparation for nursing needs to be equal to or better than that for other major health professions. In 1971, Mayhew admonished us at SREB that there is a trend for the master's degree to become the first professional degree. Will nurses forever remain breathlessly behind — second-class citizens in the university, dependent practitioners in health care settings? Don't we recognize and value our unique, though collaborative, role in providing health care?

Let me remind you that the Carnegie Study of Higher Education has already pointed to the need for graduates to have the tools to process knowledge at a higher level than in the past. We are moving from the age of specialists to the age of comprehensivists. Cleveland, in a special issue of *Change Magazine*, urges us to go forward to basics. We will have to widen our perspectives beyond our particular discipline or profession. We need to be interdisciplinary, interprofessional, interdepartmental, and international. We cannot afford to repeat our past mistakes, pursuing growth without thought to the consequences. We plunged into nuclear power for electricity before we even asked questions about safety and disposal of waste. We did not envision the consequences of the multiplication of associate degree nursing programs. We can afford no less than a global perspective of all studies. We cannot compartmentalize and wall off knowledge by premature specialization.

Position 2: The Case for Clinical Specialization

Barbara Brodie

The soul of nursing is patient care. It is patient care that infuses nursing with its life, its purpose, and its vitality. This position underlies the major premise of my argument that clinical specialization at the graduate level best prepares the nurse of the future. The need for clinical specialization at a master's level can be argued from three major views:

(1) the student
(2) the profession
(3) the patient.

The Student

Undergraduate nursing education is a basic program designed to initiate the novice into the world of nursing. It is a highly intense program that introduces the student to the full range of human health care problems and concerns. By its very nature it is a generalist program, designed to produce a beginning practitioner for *any first level* position in a hospital or health care agency. Thus, in place of depth in a select area, undergraduate course content and clinical experiences generally emphasize beginning knowledge and skills in nursing.

The transition from new graduate to professional nurse is an important phase that must be mastered by all graduates. It is a time when they must test the currency of their knowledge, skills, and beliefs about people, nursing, and themselves as they struggle to provide nursing care to patients.

It is a time when they must learn what kind of nurses they are — their strengths and their weaknesses, and where their career goals lie. For most, it is a maturing and tempering time, a time to master the role of a professional nurse.

All are familiar with Kramer's work *Reality Shock* in which she so dramatically portrays the vicissitudes that confront young graduates. We are equally familiar with her portrayal of the young graduates' disenchantment with nursing and, for some, their "lateral arabesque dance" back to graduate school to avoid the clinical problems. As a human developmentalist I view her data somewhat differently, for what I see and hear daily from those students who return to school is that they are in a developmental crisis. The decision to become a nurse, to function in an envisioned role, is no longer as comfortable to them as it was when they made this decision at 18 or 20 years of age. At this point they are re-examining their lives and have opted to make a different kind of commitment to nursing. For the vast majority of students who enter graduate work every year, this commitment is still to patient care, and they seek programs that will help them translate this new commitment into specific clinical knowledge and skills. Their dedication to caring for patients as professional nurses remains their highest priority and also serves as the motivational force behind their action to return to school.

Thus, as faculty, we are dealing with nurses who have consciously and deliberately made a *career choice*. A well-designed graduate program will provide its students with not only the opportunity but the challenge of asking the questions: Who am I? What am I? Why am I? A nursing graduate program with emphasis on clinical specialization will also provide students the opportunity and challenge of discovering: Who am I as a nurse? What kind of nurse am I? Why am I a nurse? And lastly, How can I be a more effective nurse? A graduate student, although previously exposed to patient care problems, examines nursing content from a different and a more mature perspective than does an undergraduate.

A program that stresses specialization allows the student not only the opportunity to gather additional nursing and medical knowledge and skills, but also time to test them with patients and colleagues. By including the basic administrative and management perspectives demanded of a nursing leader in a clinical situation, the student will be able to begin analysis of the social structure of a working situation and to develop an individualized style of leadership. Armed with these competencies, the master's-prepared nurse not only can discuss with competency the nursing care of patients with other health professionals, but also can implement these ideas and concepts in the work setting.

The Profession

A program that emphasizes clinical specialization must incorporate the newest of knowledge in the care of patients. Through the interplay of patient and student/faculty contacts, the clinical base of nursing is constantly being explored and developed. Questions of efficiency, effectiveness, and at times even economics, are explored and, hopefully, tentative answers will be forthcoming.

Programs with emphasis on clinical specialization work closely with clinical staffs to bridge the gap between nursing service and education. I believe there is more mutual respect and harmony in values when nursing care is stressed in our curricula. Furthermore, it is not as easy to lose sight of the soul of nursing, patient care, if students and faculty deal with human concerns and health problems on a daily basis.

Patient Care

The last point of this presentation concerns patient care. Clinical specialization at the graduate level has advanced the level and quality of patient care. It has accomplished this in a variety of ways.

(1) It has developed knowledge, skills, and techniques that have become standard practice in hospitals across the land. As an example, the nursing of children has benefited immensely from the ideas of graduate nursing faculty, such as Florence Blake and Florence Erickson who stressed the clinical role of nursing. Through their teaching and written words, nursing care and hospital policies became more child-oriented. The recognition of the needs of children to have parents present and to have care designed to meet their developmental needs became the norm in pediatric units across the nation.

(2) Because clinical content was stressed at the graduate level, the undergraduate curriculum began to integrate this knowledge and emphasize it as desired nursing care. This filtration process, from graduate to undergraduate, helped produce a cadre of nurses dedicated to the cause of minimizing the emotional trauma that illness and hospitalization often produce on children.

(3) Clinically prepared graduate nurses, in conjunction with staff nurses, have set the standards of care in hospitals in this country.

In closing I would like to share a mythical tale with you about the *USS Nautilus* and its crew. This submarine, the first nuclear powered ship of the Navy, was the dream of many, but most particularly of Admiral Hyman Rickover. When its keel was laid in 1950 the then-Captain Rickover gathered his staff to discuss how best to prepare the future crew of the *Nautilus*. Immediately there were those who argued for a specialization vs. a generalist's preparation. All noted that they were dealing with professional sailors who had previous experience in submarines. Furthermore, all noted that these men had made their career choice by choosing the submarine branch of service.

But the generalist argued:

A breadth of knowledge will allow the crew to function in a variety of situations, an attribute that may be very important in an emergency situation. They would have the ability to examine problems from a broader basis and thus be able to arrive at relationships not seen by specialists. Lastly, they would be better able to speak the language of other specialists, such as electronic engineers and nuclear physicists, thus achieving more closeness and harmony among the crew.

The specialists countered:

The complexity of technology and knowledge demand a great depth of understanding and mastery. They reasoned that it was not possible to be an expert and generalist at the same time, especially with the estimated "half-life" of scientific information at 2-plus years. They believed that the crew needed to be composed of experts trained to a razor's edge of knowledge, and that if an emergency arose, only an expert could handle it safely and competently.

The decision of how to best educate this special crew was extremely important. The *USS Nautilus* represented the future of the United States Navy. Not only did it cost over $55 million and hold the lives of 110 officers and crew, but it was the first nuclear ship of the line. Serving as the prototype of all future submarines, this ship had to be tested to find the limits of its technology and crew.

The specialist route won the argument, and when the ship was launched in 1955, it embarked on an experiment that was to last 25 years. During its active service tremendous amounts of knowledge were garnered about oceanography, the polar region, the psychology of men under stress, and the use of nuclear power and weaponry. Although most of this information is classified, enough has become available to know the success of this experiment.

Focusing on clinical specialization at the graduate level serves the patient, the profession, and the student well because it both encourages the development of new knowledge and skills and provides for a continuous recommitment of nursing and nurses to the soul of nursing — patient care.

REFERENCES

PURPOSES OF GRADUATE EDUCATION: AN EVALUATION

Jean A. Kelley

American Nurses' Association. *Statement on graduate education in nursing.* Kansas City: American Nurses' Association, 1978.

Cleland, V. Developing a doctoral program. *Nursing Outlook*, 1975, *24*, 631-635,

Commission on Nursing Education. *Statement on graduate education.* New York: American Nurses' Asso-tion, 1969.

Commission on Nursing Education. *Statement on graduate education in nursing.* Kansas City: American Nurses' Association, 1978.

The degree of Doctor of Philosophy: A statement of policy. Washington, D.C.: Association of Graduate Schools, 1979.

Grossman, H. Diversity in graduate nursing education. *Nursing Outlook*, 1972, *20*, 464-467.

Heiss, A. *Challenge to graduate schools.* San Francisco: Jossey-Bass, Inc., 1970.

Kelley, J. A. The professional doctorate in nursing from the viewpoint of nursing science. *Proceedings of the 1978 Forum on Doctoral Education in Nursing.* Chicago: Rush University, 1978.

MacPhail, J. Doctor of Nursing program: The professional doctorate in nursing. *Proceedings of the 1978 Forum on Doctoral Education in Nursing.* Chicago: Rush University, 1978.

Master's education in nursing: Route to opportunities in contemporary nursing. New York: National League for Nursing, 1978.

Maxwell, A. M. The preparation of teachers of nursing. *Nursing Forum*, 1968, *7*, 365-374

Mayhew, L. B., and Ford, P. J. *Reform in graduate and professional education.* San Francisco: Jossey-Bass, Inc., 1974.

McLane, A. M. Core competencies of master's prepared nurses. *Nursing Research*, 1978, *27*, 48-53.

NLN statement on doctoral education in nursing. New York: Council on Baccalaureate and Higher Degree Programs, National League for Nursing, November 20, 1980.

Requirements for the Ph.D.: A policy statement. Washington, D.C.: Council of Graduate Schools, 1977.

Sanford, N. Graduate education then and now. *American Psychologist*, 1976, 756-774.

NURSING THEORY AND PRACTICE: A PHILOSOPHICAL DEBATE

Kathleen Goldblatt

Beare, P. G., Daniel, E. D., Gover, V.E., Gray, C. J., Lancaster, J., and Sloan, P. E. The real vs ideal content in master's curricula in nursing. *Nursing Outlook*, 1980, *28*.

Chin, P. A model for theory development in nursing. *Advance in Nursing Science*, 1:1, October, 1978.

Donaldson, S. K. Defining the clinical content of nursing. *Proceedings of the 1979 Forum on Doctoral Education in Nursing.* San Francisco, California, June 28-29, 1979.

Flasknud, J. H., and Halloran, E. J. Areas of agreement in nursing theory development. *Advances in Nursing Science*, 3:1, October, 1980.

Johnson, J. E. Preparing doctorates in nursing to participate in the scientific community. *Proceedings of the 1979 Forum on Doctoral Education in Nursing.* San Francisco, California, June 28-29, 1979.

Johnson, D. E. The significance of nursing care. *American Journal of Nursing*, 1961, *61*, 63-66.

Kelley, J. The professional doctorate in nursing from the viewpoint of nursing science. *Proceedings of the 1978 Forum on Doctoral Education in Nursing.* Chicago: Rush University, June 29-30, 1978.

Nightingale, F. *Notes on nursing: What it is and what it is not.* London: Harrison, 1860.

Rogers, M. E. *Introduction to the theoretical basis of nursing.* Philadelphia: F. A. Davis Company, 1970.

ESSENTIAL CONTENT: NURSING THEORY AND RESEARCH

Nita W. Davidson

Bloom, B. S. (Ed.). *Taxonomy of educational objectives. Handbook 1: Cognitive domain.* New York: David McKay Company, Inc., 1956.

Chin, P. A model for theory development in nursing. *Advances in Nursing Science*, 1:1, October, 1978.

Fawcett, J. The relationship between theory and research: A double helix. *Advances in Nursing Science*, 1:1, October, 1978.

Fleming, J. Teaching nursing research: Content. *Nurse Educator*, January-February, 1980.

Kerlinger, F. N. *Foundations of behavioral research* (2nd ed.). New York: Holt, Rinehart and Winston, Inc., 1973.

Piaget, J. Piaget's theory. In P. H. Mussen (Ed.). *Carmichael's manual of child psychology (3rd ed.).* New York: John Wiley Sons, Inc., 1970.

Wilson, H. S. An analytical model of quality in nursing doctoral dissertations. *Proceedings of the 1979 Forum on Doctoral Education in Nursing*. San Francisco, California, June 28-29, 1979.

FUNCTIONAL ROLES

II TEACHING

Myrtis J. Snowden

Guralnik, David E., Ed. *Webster's new world dictionary, 2nd collegiate edition*, 1970.

Hodenfield, G. and Stinnett, T. M. *The education of teachers*. Englewood Cliffs, N.J.: Prentice Hall Inc., 1961.

Kline, William A. and Dale, Lawrence. A modest proposal for changing teacher education. *Teachers College Record*, 1975, *77*, 99.

Masher, Ralph L., and Purpel, David E. *Supervision: The reluctant profession.* Boston, Mass: Houghton-Mifflin, 1972.

Nursing education. *School and Society*, 1933, 37, 152.

Payne, William H. Science of education: Its nature, its method, and some of its problems. In Margaret Gillett and John Laska (Eds.), *Foundation studies in education*. Metuchen, N.J.: The Scarecrow Press Inc., 1973.

Watson, Joellen. The evolution of nursing education in the United States: 100 years of a profession for women. *Journal of Nursing Education*, 1977, *16*, 31-37.

Wilhelms, Fred T. Realignments for teacher education. In Margaret Lindsey (Ed.), *Teacher education: Future directions*. Association of Teacher Education: Report of 50th Anniversary Conference of the Association of Student Teaching. Washington, D.C., 1970.

III NURSING PRACTICE ADMINISTRATION

Lois C. Malkemes

Drucker, Peter. *Management.* New York: Harper and Row, 1974.

Kazmier, Leonard J. *Principles of management* (3rd ed.). New York: McGraw-Hill, 1974.

Reum, Earl. Nursing education of future nursing administrators: Viewpoint of a practicing nurse executive. In Lena Alexsandrowing (Ed.), *Nursing administration present and future*. New York: National League for Nursing, 1978.

IV RESEARCH

Juanita W. Fleming

American Nurses' Association. *Statement on graduate education in nursing*. New York: American Nurses' Association, 1969.

Commission on Nursing Research. *Generating a scientific basis for nursing practice: Research priorities for the 1980s*. Kansas City: American Nurses' Association, 1980.

Department of Baccalaureate and Higher Degree Programs. *Characteristics of graduate education in nursing* (Pub. #15-1318). New York: National League for Nursing, 1979.

Despite problems, research increases at nursing schools. *Chronicle of Higher Education*, November 10, 1980.

Downs, Florence. Doctoral education in nursing: Future directions. *Nursing Outlook*, 1978, *26*, 56-61.

Gortner, Susan. Research for a practice profession. *Nursing Research*, 1975, *24*, 193.

Notter, Lucille. The case for nursing research. *Nursing Outlook*, 1975, *23*, 760-763.

Theories of Piaget, who died this month, inspire growing band of U. S. professors. *Chronicle of Higher Education*, September 29, 1980.

GENERIC GRADUATE PROGRAMS IN NURSING

Sylvia E. Hart

Characteristics of graduate education in nursing leading to the master's degree (Pub. #15-1759). New York: National League for Nursing, 1978.

Commission on Nursing Education. *Statement on flexible patterns of nursing education*. Kansas City: American Nurses' Association, 1978.

Commission of Nursing Education. *Statement on graduate education in nursing*. Kansas City: American Nurses' Association, 1978.

DeTornyay, Reba. Proposed changes in academic preparation for nursing practice: Implications for the health care system and the educational system. In American Association of Colleges of Nursing, *Changes in nursing education: Implications for practice* (Series 79, No. 1).

Directory of nurses with doctoral degrees. Kansas City: American Nurses' Association, 1980.

Fields, Cheryl. Despite problems, research increases at nursing schools. *Chronicle of Higher Education*, November 10, 1980.

Haase, Patricia. *A proposed system for nursing: Theoretical framework, Part 2. Pathways to practice* (Vol. 4). Atlanta: Southern Regional Education Board, 1976.

Hesburgh, Theodore M., Paul A. Miller, and Charlin R. Wharton, Jr. *Patterns for life-long learning*. San Francisco: Jossey-Bass, 1974.

Murphy, Marion I. The evolution of professional degrees and roles in nursing. In American Association of Colleges of Nursing, *Changes in nursing education: Implications for practice* (Series 79, No. 1).

O'Koren, Marie L. *Nursing: Past realities and future imperatives* (Series 79, No. 2). Washington: American Association of Colleges of Nursing, 1979.

Pelczar, Michael J. *The value and future of graduate education leading to a master's degree* (Series 80, No. 2). Washington: American Association of Colleges of Nursing, 1980.

DEBATES ON ISSUES IN INNOVATIONS

II PROGRESSION TO THE NURSING DOCTORATE: HOW CAN IT BEST BE ACHIEVED?

Position 1: The Master's Degree as Prerequisite

Elizabeth Lenz

Cleland, Virginia. Developing a doctoral program. *Nursing Outlook*, 1976, *24*, 631-35.

Schlotfeldt, Rozella. The professional doctorate: Rationale and characteristics. *Nursing Outlook*, 1978, *26*, 302-11.

III SHOULD THE PRODUCT OF GRADUATE EDUCATION BE AN ADVANCED GENERALIST OR A SPECIALIST?

Position 2: The Case for Clinical Specialization

Barbara Brodie

Kramer, Marlene. *Reality shock*. St. Louis: C. V. Mosby Company, 1974.

Larsen, Clifton. The atomic submarine and Admiral Rickover. New York: Henry Holt & Company, 1954.

APPENDIX A
CONFERENCE PROGRAM

GRADUATE EDUCATION IN NURSING

issues and Future Directions

Terrace Garden Inn
Atlanta, Georgia
December 2-3, 1980

Tuesday - December 2

8:00 - 9:00 a.m. Registration — Terrace Foyer

9:00 a.m. General Session — Pageantry Hall
Patricia T. Haase presiding

Welcome

Purposes of Graduate Education:
An Evaluation
Jean A. Kelley

Discussion from Floor

Overview of Modal Curricular Patterns
Master's — LaVerne Gallman
Doctoral — William Field

Discussion from Floor

10:30 a.m. Coffee Break - Terrace Foyer

11:00 a.m. General Session — Pageantry Hall
Myrtis Snowden presiding

Panel on Content Areas

1. Nursing Theory and Practice — Kathleen Goldblatt
2. Nursing Theory and Research — Nita Davidson

Discussion from Floor

12:00 Lunch (on your own)

1:30 p.m. General Session — Pageantry Hall
Sylvia Hart presiding

Panel on Functional Roles

1. Clinical Specialist in Primary Care — Jo Jones
2. Teaching — Myrtis Snowden
3. Nursing Practice Administration — Lois Malkemes
4. Research — Juanita Fleming
5. Organizations — Ruth Seigler

2:45 p.m. Coffee Break — Terrace Foyer

3:15 p.m. Small Group Discussions

Group I — Mimosa Room — Sylvia Hart
Group II — Raintree Room — Patricia T. Haase
Group III — Rosewood Room — LaVerne Gallman
Group IV — Live Oak Room — Elizabeth Lenz
Group V — Pageantry Hall — Jean Kelley

Wednesday - December 3

9:00 a.m. General Session — Pageantry Hall
LaVerne Gallman presiding

Generic Graduate Programs
Sylvia Hart

Discussion from Floor

10:00 a.m. Coffee Break — Terrace Foyer

10:30 a.m. General Session — Pageantry Hall
Jean Kelley presiding

Debates on Issues in Innovations

1. Satellite Programs and Flexible Scheduling: Can Quality and Integrity be Maintained?
Helen Kohler, Betty Rudnick
2. Progression to the Nursing Doctorate: How Can It Best Be Achieved?
Elizabeth Lenz, Carolyn Waltz
3. Product of Graduate Education: Advanced Generalist or Specialist?
Genevieve Bartol, Barbara Brodie

12:00 p.m. Lunch (on your own)

1:30 p.m. General Session — Pageantry Hall
Virginia Jarratt presiding

Open Forum on Issues and New Directions

Conference Summary — Lorita Jenab